

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH 889  
 County Washington  
 Village or City Haguetown (No. 126, E. Balto) St. 3 Ward  
 2 FULL NAME Vincent Gerald Barnes  
 STATE OF MARYLAND  
 CERTIFICATE OF DEATH  
 Registration Dist. No. 302  
 [If death occurred in a hospital or institution, give its NAME instead of street and number.]

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX male 4 COLOR OR RACE white 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Single  
 (Write the word)  
 6 DATE OF BIRTH Aug 24, 1913  
 (Month) (Day) (Year)  
 7 AGE 5 yrs. 5 mos. 1 ds. OR 1 day, 1 hrs. 1 min. ?  
 If LESS than 1 day, hrs. min. ?

## 8 OCCUPATION

(a) Trade, profession, or particular kind of work none  
 (b) General nature of industry, business, or establishment in which employed (or employer) none

## 9 BIRTHPLACE (State or country)

10 NAME OF FATHER Studly Barnes  
 11 BIRTHPLACE OF FATHER (State or country) Md  
 12 MAIDEN NAME OF MOTHER Mary E. Kitz  
 13 BIRTHPLACE OF MOTHER (State or country) Md.

## 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Studly Barnes  
 (Address) Haguetown Md

15 Filed 1/24, 1914 Henry Davis  
 REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH 1 23, 1914  
 (Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from 1/20, 1914, to 1/23, 1914,  
 that I last saw him alive on 1/22, 1914.

and that death occurred on the date stated above, at 11 a. m.

The CAUSE OF DEATH\* was as follows:

Enterocolitis

Contributory Dysentery (Duration) 3 yrs. 3 mos. 3 ds.  
 Secondary

(Signed) John D. Smith, M. D.  
1/23, 1914 (Address) Haguetown

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death 1 yrs. 5 mos. 1 ds. In the State 1 yrs. 5 mos. 1 ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence

19 PLACE OF BURIAL OR REMOVAL Home Will DATE OF BURIAL 1/24, 1914

20 UNDERTAKER Watkins & Minnick ADDRESS Haguetown Md.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc., *Carcin-*

*oma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Traemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for violent surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED  
FEB 5 1914  
BUREAU, U. S.

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1 PLACE OF DEATH 900  
 County Washington  
 Village or City Hagerstown (No. 268, N. Center St.; 4 Ward)  
 2 FULL NAME George Th. Bush  
 Registration Dist. No. 302  
 [If death occurred in a hospital or institution, give its NAME instead of street and number.]

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED married  
 (Write the word)  
 6 DATE OF BIRTH 6 25, 1838  
 (Month) (Day) (Year)  
 7 AGE 75 yrs. 7 mos. 4 ds. If LESS than 1 day, hrs. OR min. ?  
 8 OCCUPATION (a) Trade, profession, or particular kind of work Carpenter  
 (b) General nature of industry, business, or establishment in which employed (or employer) \_\_\_\_\_  
 9 BIRTHPLACE (State or country) Pa

PARENTS  
 10 NAME OF FATHER Abraham Bush  
 11 BIRTHPLACE OF FATHER (State or country) Pa  
 12 MAIDEN NAME OF MOTHER Elizabeth Stupp  
 13 BIRTHPLACE OF MOTHER (State or country) Pa

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mary E. Bush  
 (Address) Hagerstown, Md

15 Filed 1/24, 1914 Henry Davis  
 REGISTRAR

STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 302

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH 1 24, 1914  
 (Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from May 14, 1913, to July 23, 1914,  
 that I last saw him alive on " 22, 1914

and that death occurred on the date stated above, at 10:00 a.m.,  
 The CAUSE OF DEATH\* was as follows:

arteriosclerosis, organic heart disease

(Duration) 3 yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.  
 Contributory Heart condition  
 Secondary \_\_\_\_\_

(Signed) A. S. Hoff, M. D.  
1/23, 1914 (Address) Hagerstown

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR REGENT RESIDENTS)

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. In the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Where was disease contracted, If not at place of death?

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL Rose Hill Cemetery DATE OF BURIAL 1-26-, 1914

20 UNDERTAKER Watkins & Menck ADDRESS Hagerstown Md

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

**Statement of occupation**—[Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Composer*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Garcin-*

*oma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Reverber wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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FEB 5 1914

BUREAU, V. S.



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1 PLACE OF DEATH County <u>Washington</u> 901		STATE OF MARYLAND CERTIFICATE OF DEATH	
Village or City <u>Caretown</u> (No. _____)		Registration Dist. No. <u>306</u>	
2 FULL NAME <u>Geo. M. Bushey</u>		[If death occurred in a hospital or institution, give its NAME instead of street and number.]	
PERSONAL AND STATISTICAL PARTICULARS		MEDICAL CERTIFICATE OF DEATH	
3 SEX <u>Male</u>	4 COLOR OR RACE <u>White</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED <u>Married</u> (Write the word)	
6 DATE OF BIRTH <u>6</u> <u>26</u> , 19 <u>57</u> (Month) (Day) (Year)		16 DATE OF DEATH <u>Jan</u> <u>2</u> , 19 <u>4</u> (Month) (Day) (Year)	
7 AGE <u>56</u> yrs. <u>6</u> mos. <u>6</u> ds.	If LESS than 1 day, .... hrs. OR .... min. ?		
8 OCCUPATION (a) Trade, profession, or particular kind of work <u>Lumber Dealer</u> (b) General nature of industry, business, or establishment in which employed (or employer)		17 I HEREBY CERTIFY, That I attended deceased from <u>12/25</u> , 19 <u>3</u> , to <u>Jan 2</u> , 19 <u>4</u> that I last saw him alive on <u>Jan 1</u> , 19 <u>3</u> and that death occurred on the date stated above, at <u>3:30</u> m. The CAUSE OF DEATH* was as follows: <u>Lobar Pneumonia</u>	
9 BIRTHPLACE (State or country) <u>Woodlensburg Balt. Co.</u>		(Duration) .... yrs. .... mos. .... ds.	
10 NAME OF FATHER <u>John H. Bushey</u>		Contributory (Secondary) <u>Influenza</u>	
11 BIRTHPLACE OF FATHER (State or country) <u>Woodlensburg Balt. Co.</u>		(Duration) .... yrs. .... mos. .... ds.	
12 MAIDEN NAME OF MOTHER <u>Mary Ewing</u>		(Signed) <u>Virginia Bunting</u> , M. D.	
13 BIRTHPLACE OF MOTHER (State or country) <u>Harrisburg Pa.</u>		<u>12</u> , 19 <u>4</u> (Address) <u>1169 2nd St. S.E.</u>	
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Mr. Lucy Bushey</u> (Address) <u>Caretown Md.</u>		*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.	
15 Filed <u>Jan 2</u> , 19 <u>4</u> <u>J. H. Ferguson</u> REGISTRAR		16 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death .... yrs. .... mos. .... ds. In the State .... yrs. .... mos. .... ds. Where was disease contracted, if not at place of death? Former or usual residence	
17 PLACE OF BURIAL OR REMOVAL <u>Smithsburg Md.</u>		DATE OF BURIAL <u>Jan 4</u> , 19 <u>4</u>	
20 UNDERTAKER <u>Geo. B. Hoover</u>		ADDRESS <u>Smithsburg</u>	

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

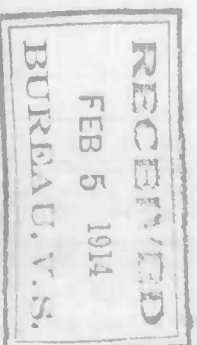
Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative wealthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry; and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mining*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Scrubw*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc.. *Carcin-*

*oma*, *Sarcoma*, etc., of \_\_\_\_\_ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As thena," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and quality, as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such. If impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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## 1 PLACE OF DEATH

902

County WashingtonVillage or City Williamsport (No. Vermont St. State Ward)STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistered No. 301

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME John E. Campbell

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Single  
(Write the word)

6 DATE OF BIRTH Jan. 18th, 1914  
(Month) (Day) (Year)

7 AGE Stillborn If LESS than 1 day, \_\_\_\_ hrs. OR \_\_\_\_ min. ?  
\_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

8 OCCUPATION  
(a) Trade, profession, or particular kind of work Child  
(b) General nature of industry, business, or establishment in which employed (or employer) Child

9 BIRTHPLACE (State or country) Maryland

PARENTS  
10 NAME OF FATHER Stahel Campbell  
11 BIRTHPLACE OF FATHER (State or country) Pennsylvania  
12 MAIDEN NAME OF MOTHER Nellie Louis  
13 BIRTHPLACE OF MOTHER (State or country) Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Nellie Louis  
(Address) Hagerstown Md.

15 Filed Jan. 18th 1914 C. E. Rickard  
Local REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Jan. 18, 1914  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Jan. 18, 1914 to Jan. 18, 1914, that I last saw him at home, 1914

and that death occurred on the date stated above, at \_\_\_\_ m, The CAUSE OF DEATH\* was as follows:

Still born

(Duration) \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Contributory (Secondary)

(Duration) \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

(Signed) D. S. Richardson, M. D.  
Jan. 18, 1914 (Address) Williamsport Md.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, OR HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds. In the State \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Williamsport Md. DATE OF BURIAL Jan. 19, 1914

20 UNDERTAKER Lewis W. Kieps ADDRESS Williamsport Md.

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[Approved by U. S. Census and American Public Health Association.]

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**Statement of cause of death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc. *Carcin-*

*oma*, *Sarcoma*, etc., of \_\_\_\_\_ (name origin: "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "As-thenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and quality as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory" (Recommendations on Statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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BUREAU, V.S.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH 903  
County WASHINGTON

Village or City HAGERSTOWN (No. 613, S. POTOMAC St.; 2 Ward)

# STATE OF MARYLAND CERTIFICATE OF DEATH

Registration Dist. No. 302

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME MARY C. DAVIS

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX FEMALE 4 COLOR OR RACE WHITE 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED SINGLE  
(Write the word)

6 DATE OF BIRTH SEPTEMBER 23, 1869.  
(Month) (Day) (Year)

7 AGE 44 yrs. 3 mos. 29 ds. If LESS than 1 day, hrs. OR min. ?

8 OCCUPATION  
(a) Trade, profession, or particular kind of work HOUSEWORK  
(b) General nature of industry, business, or establishment in which employed (or employer) " " " " " " " " " " " "

9 BIRTHPLACE (State or country) PENNA.

10 NAME OF FATHER DAVID DAVIS.

11 BIRTHPLACE OF FATHER (State or country) PENNA.

12 MAIDEN NAME OF MOTHER MARY MARTIN.

13 BIRTHPLACE OF MOTHER (State or country) PENNA.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) WILLIAM H. DAVIS

(Address) # 613 S. POTOMAC STREET

15 Filed 1/24, 1914 Henry Davis  
REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Jan 22, 1914  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Jan 3, 1914, to Jan 22, 1914.

that I last saw him alive on Jan 22, 1914.

and that death occurred on the date stated above, at 2 P m.

The CAUSE OF DEATH\* was as follows:

Heart Brights  
Musical Printing  
(Duration) yrs. 2 mos. 22 ds.

Contributory Coronary Artery of brain  
Secondary (Duration) yrs. mos. 1 ds.

(Signed) C. J. King, M. D.  
Jan 23, 1914. (Address) Frederick St.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL ROSE HILL CEMETERY DATE OF BURIAL JAN. 25, 1914

20 UNDERTAKER C. M. SUTER & SON ADDRESS HAGERSTOWN MD



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

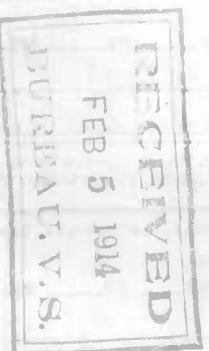
[Approved by U. S. Census and American Public Health Association.]

**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not faithfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

*oma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal *septicæmia*," "Puerperal *peritonitis*," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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## 1 PLACE OF DEATH

County WashingtonVillage or City Princessville (No. \_\_\_\_\_)

## 2 FULL NAME

Mary J. DavisSTATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 311

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Married

## 6 DATE OF BIRTH

Oct 1, 1887  
(Month) (Day) (Year)

## 7 AGE

56 yrs. 3 mos. 19 ds. If LESS than 1 day, \_\_\_\_ hrs. OR \_\_\_\_ min. ?

## 8 OCCUPATION

(a) Trade, profession, or particular kind of work

Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

## 9 BIRTHPLACE

(State or country)

Maryland

## PARENTS

## 10 NAME OF FATHER

Thomas Pickley

## 11 BIRTHPLACE OF FATHER (State or country)

Maryland

## 12 MAIDEN NAME OF MOTHER

Caroline M. Cox

## 13 BIRTHPLACE OF MOTHER (State or country)

Maryland

## 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Trisby F. Davis

(Address)

Starkshire Md.

## 15

Filed

Jan 21, 1914 V. M. Richard  
Local REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH

Jan 20, 1914  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Sept 8, 1914, to Jan 20, 1914.

that I last saw her alive on Jan 20, 1914.

and that death occurred on the date stated above, at 1:30 P. m.

The CAUSE OF DEATH\* was as follows:

Pulmonary tuberculosis(Duration) ? yrs. 4 mos. ds.Contributory  
Secondary

(Duration) \_\_\_\_ yrs. \_\_\_\_ mos. ds.

(Signed)

V. M. Richard, M. D.

Jan 21, 1914. (Address) Fair Play

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds. In the State \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Where was disease contracted,

If not at place of death?

Former or usual residence

## 19 PLACE OF BURIAL OR REMOVAL

## DATE OF BURIAL

BakersvilleJan 23, 1914

## 20 UNDERTAKER

## ADDRESS

V. M. Richard Trisby Md.

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

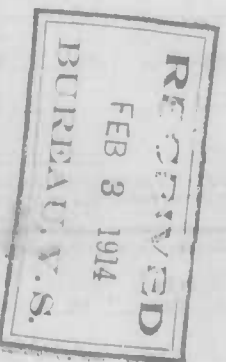
[Approved by U. S. Census and American Public Health Association.]

**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school or At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcin-*

*oma, Sarcoma, etc., of.....* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection used not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Contributory," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, STRUCK, or NONFATAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Reverber wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory" (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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## 1 PLACE OF DEATH

905

County

Washington

Village or City

Hagerstown

(No.)

528

Salmon Ave

Registration Dist. No.

302

St.; — Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

## 2 FULL NAME

Carnelia Dungan

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE W. 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Widowed

6 DATE OF BIRTH Oct 14, 1844 (Month) (Day) (Year)

7 AGE 69 yrs 3 mos 2 ds. 1 LESS than 1 day, hrs. OR mo. ?

8 OCCUPATION (a) Trade, profession, or particular kind of work House (b) General nature of industry, business, or establishment to which employed (or employer)

9 BIRTHPLACE (State or country) N.Y.

10 NAME OF FATHER Henry Youngs  
11 BIRTHPLACE OF FATHER (State or country) N.Y.  
12 MAIDEN NAME OF MOTHER Margaret Sisk  
13 BIRTHPLACE OF MOTHER (State or country) N.Y.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. Ridley  
(Address) 528 Salmon Ave

15 Filed 1/17, 1914 Henry Davis REGISTRAR

STATE OF MARYLAND  
CERTIFICATE OF DEATH

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH January 16, 1914 (Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Jan. 15, 1914, to Jan 16, 1914, that I last saw her alive on Jan 15, 1914

and that death occurred on the date stated above, at 2:30 a.m. The CAUSE OF DEATH\* was as follows:

Cerebral apoplexy

(Duration) yrs. mos. ds. Contributory (Secondary) E. Laustin

(Duration) yrs. mos. ds. (Signed) Frank M. Wutk, M. D. Jan 6, 1914 (Address) Hagerstown

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. to the State yrs. mos. ds. Where was disease contracted, If not at place of death? Former or usual residence.

19 PLACE OF BURIAL OR REMOVAL Geneva N.Y. DATE OF BURIAL Jan 20, 1914  
20 UNDERTAKER Kraiss Bros ADDRESS 33 E. Wash St

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

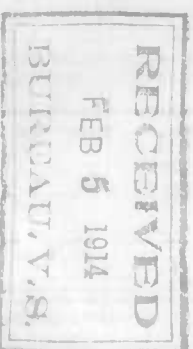
[Approved by U. S. Census and American Public Health  
Association.]

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**Statement of cause of death**—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc. *Carcin-*

*oma*, *Sarcoma*, etc., of ----- (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *10 ds.* Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and quality as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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## 1 PLACE OF DEATH

County

Washington

906

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No.

Village or City

Hagerstown (No. 256, 8th Ward)

St.; 3 Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

Charles Downin

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED  
(Write the word)

Married

6 DATE OF BIRTH

May 8, 1838

(Month)

(Day)

(Year)

7 AGE

75 yrs. 8 mos. 21 ds.

If LESS than  
1 day, hrs.

OR min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work

Farmer

(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE

(State or country)

Md

PARENTS

10 NAME OF FATHER

David Downin

11 BIRTHPLACE OF FATHER

(State or country)

Don't know

12 MAIDEN NAME OF MOTHER

Eveline Rothroff

13 BIRTHPLACE OF MOTHER

(State or country)

Don't know

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Frank Downin

(Address)

Hagerstown Md

15

Filed

129-1914 Henry Davis

REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

1-29, 1914

(Month)

(Day)

(Year)

17 I HEREBY CERTIFY, That I attended deceased from July 5, 1913, to Aug 28, 1914

that I last saw him alive on Aug 27, 1914

and that death occurred on the date stated above, at m.

The CAUSE OF DEATH\* was as follows:

Atherosclerosis and  
general debility  
(Duration) 25 yrs. mos. ds.

Contributory  
Secondary

Cardiac Catheter  
(Duration) yrs. 3 mos. ds.

(Signed) J. C. Duggan, M. D.  
1/28, 1914 (Address) Hagerstown

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

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At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence.

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Rose Hill Cemetery

Jan. 31, 1914

20 UNDERTAKER

ADDRESS

Watkins &amp; Shinnick

Hagerstown Md

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

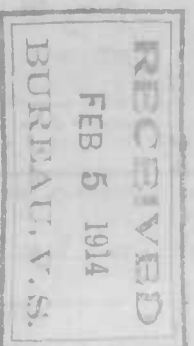
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**Statement of cause of death**—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc., *Carcin-*

*oma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Tremula," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal, septicaemia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH 907  
County Sharpsburg

Village or City near Bakersville (No. \_\_\_\_\_, St.; \_\_\_\_\_ Ward)

2 FULL NAME Mary Ellen Eakle

# STATE OF MARYLAND CERTIFICATE OF DEATH

Registration Dist. No. 300

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Single  
(Write the word)

6 DATE OF BIRTH Mar. 25, 1853  
(Month) (Day) (Year)

7 AGE 60 yrs. 9 mos. 29 ds. If LESS than 1 day, \_\_\_\_\_ hrs. OR \_\_\_\_\_ min. ?

8 OCCUPATION  
(a) Trade, profession, or particular kind of work At Home  
(b) General nature of industry, business, or establishment in which employed (or employer) \_\_\_\_\_

9 BIRTHPLACE (State or country) Maryland

10 NAME OF FATHER George Eakle

11 BIRTHPLACE OF FATHER (State or country) Maryland

12 MAIDEN NAME OF MOTHER Mary A. Hammond

13 BIRTHPLACE OF MOTHER (State or country) Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs C E Keamsburg  
(Address) Sharpsburg Md

15 Filed 1/25/ 1914 Chas. N. Hoffmaster  
REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH July 24, 1914  
(Month) (Day) (Year)

17 I HEREBY CERTIFY That I attended deceased from July 23, 1914 to July 24, 1914.

that I last saw her alive on July 24, 1914.

and that death occurred on the date stated above, at 330 P m.

The CAUSE OF DEATH\* was as follows:

chronic pyelocystitis.  
toxic nephritis.

(Duration) 2 yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Contributory  
Secondary

(Signed) W. M. Reichard, M. D.  
July 25, 1914 (Address) Fair Play.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. in the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Where was disease contracted,  
If not at place of death?

Former or  
usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL

Bakersville

DATE OF BURIAL

1/26/, 1914

20 UNDERTAKER

W. C. Reichard

ADDRESS

Fair Play Md

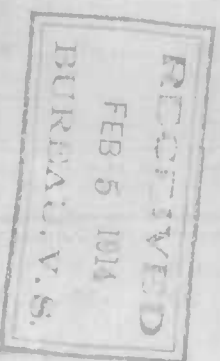
# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Plumber*, *Physician*, *Composer*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not faintly employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc., *Carcinoma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Træmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, suicidal, or homicidal, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Reverber wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death\* approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH County <u>Washington</u> <u>908</u>			STATE OF MARYLAND CERTIFICATE OF DEATH <i>Registration Certificate No. 307</i> Registered No. _____	
Village or City <u>Rohrsville Md</u> (No. _____) St; _____ Ward)			[If death occurred in a hospital or institution, give its NAME instead of street and number.]	
2 FULL NAME <u>Mary C Easton</u>				
PERSONAL AND STATISTICAL PARTICULARS				
3 SEX <u>Female</u>	4 COLOR OR RACE <u>White</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED <u>Married</u> (Write the word)		
6 DATE OF BIRTH <u>9</u> (Month) <u>2</u> (Day) <u>1848</u> (Year)				
7 AGE <u>65</u> yrs. <u>4</u> mos. <u>25</u> ds. If LESS than 1 day, ____ hrs. OR ____ min. ?				
8 OCCUPATION (a) Trade, profession, or particular kind of work <u>None</u> (b) General nature of industry, business, or establishment in which employed (or employer) <u>None</u>				
9 BIRTHPLACE (State or country) <u>Rohrsville Md</u>				
PARENTS	10 NAME OF FATHER <u>Joseph Rohrer</u>			
	11 BIRTHPLACE OF FATHER (State or country) <u>Rohrsville Md</u>			
	12 MAIDEN NAME OF MOTHER <u>Elisbeth Thomas</u>			
	13 BIRTHPLACE OF MOTHER (State or country) <u>Rohrsville Md</u>			
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Daniel Easton</u> (Address) <u>Rohrsville Md</u>				
15 Filed <u>Jan 28</u> , 191 <u>4</u> <u>C. D. Baker</u> REGISTRAR				
MEDICAL CERTIFICATE OF DEATH				
16 DATE OF DEATH <u>Jan 27</u> , 191 <u>4</u> (Month) (Day) (Year)				
17 I HEREBY CERTIFY, That I attended deceased from <u>April 1</u> , 191 <u>3</u> , to <u>Jan 25</u> , 191 <u>4</u> , that I last saw him alive on <u>Jan 25</u> , 191 <u>4</u> and that death occurred on the date stated above, at <u>12</u> m.				
THE CAUSE OF DEATH* was as follows: <u>Valvular Heart Disease</u> (Duration) <u>1</u> yrs. ____ mos. ____ ds.				
Contributory (Secondary) _____				
(Signed) <u>George H. Jouton</u> , M. D. <u>Jan 27</u> , 191 <u>4</u> (Address) <u>Baltimore Md</u>				
*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.				
18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death ____ yrs. ____ mos. ____ ds. In the State ____ yrs. ____ mos. ____ ds.				
Where was disease contracted, If not at place of death? Former or usual residence _____				
19 PLACE OF BURIAL OR REMOVAL <u>Rohrsville Md</u>				DATE OF BURIAL <u>1-31</u> , 191 <u>4</u>
20 UNDERTAKER <u>C. L. Sumner &amp; Co</u>				ADDRESS <u>Kearneysville Md</u>
If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.				



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

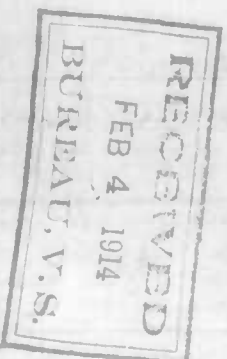
[Approved by U. S. Census and American Public Health Association.]

**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Composer*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mining*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not casually employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc., *Carcin-*

*oma*, *Sarcoma*, etc., of ..... (name or lesion; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Anemia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Typhemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH 909  
 County Washington  
 Village or City Dist (No. 5 St. 66 Ward)  
 2 FULL NAME Sarah A. Exline  
 (If death occurred in a hospital or institution, give its NAME instead of street and number.)  
 Registration Dist. No. 304

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED married  
 (Write the word)  
 6 DATE OF BIRTH May 8, 1841  
 (Month) (Day) (Year)  
 7 AGE 72 yrs. 8 mos. 15 ds. If LESS than 1 day, hrs. OR min. ?

## 8 OCCUPATION

(a) Trade, profession, or particular kind of work Housewife  
 (b) General nature of industry, business, or establishment in which employed (or employer)

## 9 BIRTHPLACE (State or country)

W. Virginia

## 10 NAME OF FATHER

Mr W. Horton

## 11 BIRTHPLACE OF FATHER (State or country)

W. Virginia

## 12 MAIDEN NAME OF MOTHER

Mary Ellen Horton

## 13 BIRTHPLACE OF MOTHER (State or country)

W. Virginia

## 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

William Exline

(Address)

Wauveo 16 Md.

## 15

Filed

1/24, 1914

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REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Jan 23, 1914  
 (Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Jan 17, 1914, to Jan 23, 1914,  
 that I last saw him alive on Jan 22, 1914.

and that death occurred on the date stated above, at 1:50 m.  
 The CAUSE OF DEATH\* was as follows:

Paralysis

(Duration) yrs. mos. ds.

## Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) W. S. Gray, M. D.

1-24, 1914 (Address) Wauveo Md.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence

## 19 PLACE OF BURIAL OR REMOVAL

## DATE OF BURIAL

Wauveo 16 Md

1/25, 1914

## 20 UNDERTAKER

## ADDRESS

W. S. Gray

Wauveo 16 Md

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

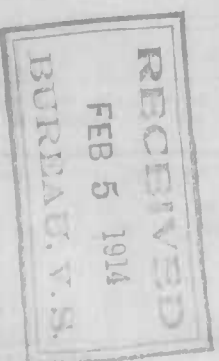
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*oma*, *Sarcoma*, etc., of \_\_\_\_\_ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 da.*; *Bronchopneumonia* (secondary), *10 da.* Never report mere symptoms or terminal conditions, such as "Anæmia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, suicidal, or homicidal, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH County <u>Washington</u>		910	STATE OF MARYLAND CERTIFICATE OF DEATH	
Village or City <u>Hagerstown</u> (No. <u>208</u> , E. Franklin St.; <u>4</u> Ward)		Registration Dist. No. <u>982</u>		[If death occurred in a hospital or institution, give its NAME instead of street and number.]
2 FULL NAME <u>Edward Irvin Favorite</u>				
PERSONAL AND STATISTICAL PARTICULARS				
3 SEX <u>Male</u>	4 COLOR OR RACE <u>white</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED <u>Single</u> (Write the word)		
6 DATE OF BIRTH <u>March 14</u> , 18 <u>69</u> (Month) (Day) (Year)				
7 AGE <u>44</u> yrs. <u>9</u> mos. <u>28</u> ds.		If LESS than 1 day, <u>    </u> hrs. <u>    </u> min. ?		
8 OCCUPATION (a) Trade, profession, or particular kind of work <u>Machinist</u> (b) General nature of industry, business, or establishment in which employed (or employer) <u>Langers Lumber Co.</u>				
9 BIRTHPLACE (State or country) <u>Md</u>				
PARENTS	10 NAME OF FATHER <u>H. J. Favorite</u>			
	11 BIRTHPLACE OF FATHER (State or country) <u>Md</u>			
	12 MAIDEN NAME OF MOTHER <u>Ellen A. Favorite</u>			
13 BIRTHPLACE OF MOTHER (State or country) <u>Md</u>				
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Miss Jane C. Favorite</u> (Address) <u>Hagerstown Md.</u>				
15 Filed <u>7/10</u> , 191 <u>4</u> <u>Henry Davis</u> REGISTRAR				
MEDICAL CERTIFICATE OF DEATH				
16 DATE OF DEATH <u>1</u> <u>10</u> , 191 <u>4</u> (Month) (Day) (Year)				
17 I HEREBY CERTIFY, That I attended deceased from <u>12/24</u> , 19 <u>44</u> , to <u>1/9</u> , 191 <u>4</u> , that I last saw him alive on <u>1/9</u> , 191 <u>4</u> , and that death occurred on the date stated above, at <u>    </u> m. The CAUSE OF DEATH* was as follows: <u>Endocarditis</u> <u>Septicemia</u> <u>Pneumonia (simple)</u> (Duration) <u>    </u> yrs. <u>    </u> mos. <u>    </u> ds. Contributory <u>    </u> Secondary <u>    </u> (Signed) <u>Victor Mueller Jr.</u> , M. D. <u>7/10</u> , 191 <u>4</u> (Address) <u>Hagerstown Md.</u> *State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. 18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death <u>    </u> yrs. <u>    </u> mos. <u>    </u> ds. In the State <u>    </u> yrs. <u>    </u> mos. <u>    </u> ds. Where was disease contracted, If not at place of death? Former or usual residence <u>    </u> 19 PLACE OF BURIAL OR REMOVAL <u>Rose Hill</u> DATE OF BURIAL <u>7/12</u> , 191 <u>4</u> 20 UNDERTAKER <u>Watkins &amp; Minnick</u> ADDRESS <u>Hager Md.</u>				

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

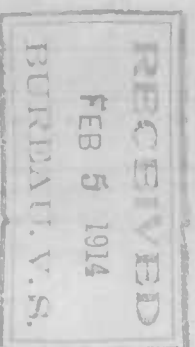
[Approved by U. S. Census and American Public Health Association.]

**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Former (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum*, etc., *Carcin-*

*oma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Scule," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH 911  
 County Washington  
 Village or City Hagerstown (No. 146 Background St. 4 Ward)  
 2 FULL NAME Lillie L. Fackler  
 Registration Dist. No. 302  
 [If death occurred in a hospital or institution, give its NAME instead of street and number.]

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX <u>female</u>	4 COLOR OR RACE <u>white</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED <u>Married</u> (Write the word)
6 DATE OF BIRTH <u>June 21, 1877</u> (Month) (Day) (Year)		
7 AGE <u>36</u> yrs. <u>6</u> mos. <u>14</u> ds.		If LESS than 1 day, .... hrs. OR .... min. ?
8 OCCUPATION (a) Trade, profession, or particular kind of work. <u>House wife</u> (b) General nature of industry, business, or establishment in which employed (or employer) _____		
9 BIRTHPLACE (State or country) <u>Md</u>		
PARENTS	10 NAME OF FATHER <u>John F. Boward</u>	
	11 BIRTHPLACE OF FATHER (State or country) <u>Md.</u>	
	12 MAIDEN NAME OF MOTHER <u>Emma Shaper</u>	
	13 BIRTHPLACE OF MOTHER (State or country) <u>Md.</u>	

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Blair Fackler

(Address)

Hagerstown Md.

15

Filed

1/5, 1914 Henry Davis  
REGISTRARSTATE OF MARYLAND  
CERTIFICATE OF DEATH

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Jan 4, 1914  
 (Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Dec 17, 1913 to Jan 4, 1914  
 that I last saw her alive on Jan 4, 1914  
 and that death occurred on the date stated above, at 11:50 p.m.  
 The CAUSE OF DEATH\* was as follows:  
La Grippe  
 (Duration) .... yrs. .... mos. 7 ds.  
 Contributory Thromboplegia  
 Secondary (Duration) .... yrs. .... mos. 7 ds.  
 (Signed) M. B. Morgan, M. D.  
Jan 5, 1914 (Address) Hagerstown Md.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death .... yrs. .... mos. .... ds. In the State .... yrs. .... mos. .... ds.

Where was disease contracted, If not at place of death? \_\_\_\_\_

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Rose Hill 1/5, 1914

20 UNDERTAKER ADDRESS

Watkins Minnich Hag. Md.

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

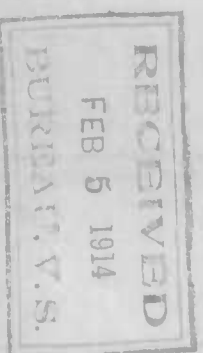
[Approved by U. S. Census and American Public Health Association.]

**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc., *Carcin-*

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912

## PLACE OF DEATH

County

Washington

Village or City

Kear Pleasant Valley

(No.)

FULL NAME

Jonathan Frey

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No.

306

St.; Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED married (Write the word)

6 DATE OF BIRTH

8 7 1891  
(Month) (Day) (Year)

7 AGE

72 yrs. 9 mos. 9 ds. OR LESS than 1 day, hrs. OR mo. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work

Farmer

(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country)

Hallsville Ind. Md.

## PARENTS

10 NAME OF FATHER

Jonathan Frey

11 BIRTHPLACE OF FATHER (State or country)

Hallsville

12 MAIDEN NAME OF MOTHER

Elizabeth Ambros

13 BIRTHPLACE OF MOTHER (State or country)

Hallsville

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

Informant

Charlie Frey

(Address)

Smithsburg

15

Filed

January 26, 1914

John W. G. Registrar

REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Jan 26, 1914  
(Month) (Day) (Year)

17

I HEREBY CERTIFY, That I attended deceased from

Sept 10, 1913, to Jan 26, 1914.

that I last saw him alive on Jan 26, 1914.

and that death occurred on the date stated above, at 5 A. M.

The CAUSE OF DEATH\* was as follows:

Cerebral apoplexy

(Duration) yrs. 3 mos. ds.

Contributory (Secondary)

Lobar pneumonia

(Duration) yrs. mos. 3 ds.

(Signed)

J. A. H. H. H.

M. D.

Jan 26, 1914 (Address) Smithsburg Ind.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Bell's Graveyard

Jan 28th, 1914

20 UNDERTAKER

ADDRESS

Geo. B. Hoover

Smithsburg

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

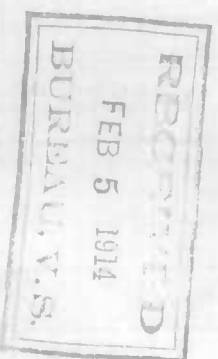
[Approved by U. S. Census and American Public Health Association.]

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**Statement of cause of death**—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc.. *Carcin-*

*oma*, *Sarcoma*, etc., of \_\_\_\_\_ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and quality as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH County <u>Nashington</u> 913		STATE OF MARYLAND CERTIFICATE OF DEATH 313	
Village or City <u>Highfield</u> (No. <u>90</u> )		Registration Dist. No. <u>139</u>	
2 FULL NAME <u>Susanna Elizabeth Gall</u>		[If death occurred in a hospital or institution, give its NAME instead of street and number.]	
PERSONAL AND STATISTICAL PARTICULARS			
3 SEX <u>Female</u>	4 COLOR OR RACE <u>White</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED <u>Widowed</u> (Write the word)	
6 DATE OF BIRTH <u>July 15<sup>th</sup>, 1837</u> (Month) (Day) (Year)			
7 AGE <u>76</u> yrs. <u>6</u> mos. <u>6</u> ds. If LESS than 1 day, ____ hrs. OR ____ min. ?			
8 OCCUPATION (a) Trade, profession, or particular kind of work <u>no occupation</u> (b) General nature of industry, business, or establishment in which employed (or employer)			
9 BIRTHPLACE (State or country) <u>Maryland</u>			
PARENTS	10 NAME OF FATHER <u>Joseph McLain</u>		
	11 BIRTHPLACE OF FATHER (State or country) <u>Maryland</u>		
	12 MAIDEN NAME OF MOTHER <u>Susanna Eyler</u>		
13 BIRTHPLACE OF MOTHER (State or country) <u>Maryland</u>			
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Mrs. Nora De Lawter</u> (Address) <u>Highfield Md</u>			
15 FILED <u>Jan 12, 1914</u> <u>C. V. Stein</u> <u>Dr. J. C. Beck</u> REGISTRAR			
MEDICAL CERTIFICATE OF DEATH			
16 DATE OF DEATH <u>Jan 21<sup>st</sup>, 1914</u> (Month) (Day) (Year)			
17 I HEREBY CERTIFY, That I attended deceased from <u>Jan 19<sup>th</sup>, 1914</u> to <u>Jan 21<sup>st</sup>, 1914</u> , that I last saw her alive on <u>Jan 20<sup>th</sup>, 1914</u> and that death occurred on the date stated above, at <u>8-55 am</u> . The CAUSE OF DEATH* was as follows: <u>Chronic Bronchitis</u> (Duration) <u>34</u> yrs. mos. ds.			
Contributory (Secondary) <u>General debility due to age</u> (Duration) ____ yrs. ____ mos. ____ ds.			
(Signed) <u>C. L. Wachtel</u> , M. D. <u>Jan 21, 1914</u> (Address) <u>Labellawells Md</u>			
*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.			
18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death ____ yrs. ____ mos. ____ ds. In the State ____ yrs. ____ mos. ____ ds. Where was disease contracted, If not at place of death? Former or usual residence ____			
19 PLACE OF BURIAL OR REMOVAL <u>Bethel Cemetery</u>		DATE OF BURIAL <u>Jan 23, 1914</u>	
20 UNDERTAKER <u>F. E. Booc</u>		ADDRESS <u>Haynesboro Pa</u>	
If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.			



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

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**Statement of cause of death**—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc. *Carcin-*

RECEIVED

MAR 5 1914

BUREAU, V.S.

and *Sarcoma*, etc., of

(name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic tubular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Anæmia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Tremor," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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RECEIVED

FEB 2 1914

BUREAU, V.S.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH  
County Washington 914  
Village or City Sharpsburg No. 24 St.; ..... Ward)  
2 FULL NAME Laura H. Hatzel Registered No. 300

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Single  
(Write the word)  
6 DATE OF BIRTH 13 16, 1858  
(Month) (Day) (Year)

7 AGE 56 yrs. 18 mos. 18 ds. If LESS than 1 day, ..... hrs. OR ..... min. ?

8 OCCUPATION  
(a) Trade, profession, or particular kind of work None  
(b) General nature of industry, business, or establishment in which employed (or employer) None

9 BIRTHPLACE (State or country) Sharpsburg

10 NAME OF FATHER Gottlieb Hatzel

11 BIRTHPLACE OF FATHER (State or country) Germany

12 MAIDEN NAME OF MOTHER Christiana Kiedman

13 BIRTHPLACE OF MOTHER (State or country) Bever Crank

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Millard Showman

(Address) Sharpsburg Md

15 Filed 1/25/, 1914 Chas. N. Hoffmaster

REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Jan. 24, 1914  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Jan. 23, 1914, to Jan. 24, 1914, that I last saw her alive on Jan. 24, 1914.

and that death occurred on the date stated above, at about 3 p.m.

The CAUSE OF DEATH\* was as follows:

Tetanus

(Duration) ..... yrs. .... mos. ✓ ds.

Contributory (Secondary)

(Duration) ..... yrs. .... mos. .... ds.

(Signed) E. M. Emmott, M. D.

Jan. 24, 1914. (Address) Sharpsburg, Md.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ..... yrs. .... mos. .... ds. to the State ..... yrs. .... mos. .... ds.

Where was disease contracted, if not at place of death?

Former or usual residence.....

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Sharpsburg Md 1 = 27, 1914

20 UNDERTAKER ADDRESS

C. L. Sullivan & Co Kearneysville

Md

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

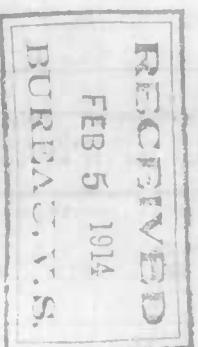
[Approved by U. S. Census and American Public Health Association.]

**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Composer*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (1) *Spinner*, (2) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household, only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not faithfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc. *Carcin-*

*oma*, *Sarcoma*, etc., of \_\_\_\_\_ (name origin: "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Anæmia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Typhemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such. If impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH County <u>Washington</u> Village or City <u>near weverton</u> (No. _____) St.; _____ Ward)		STATE OF MARYLAND CERTIFICATE OF DEATH Registered No. <u>310</u> [If death occurred in a hospital or institution, give its NAME instead of street and number.]	
2 FULL NAME <u>Mary Eliza Holmes</u>			
PERSONAL AND STATISTICAL PARTICULARS			
3 SEX <u>Female</u>	4 COLOR OR RACE <u>White</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <u>Widow</u>	
6 DATE OF BIRTH <u>Aug 2</u> , 18 <u>97</u> (Month) (Day) (Year)			
7 AGE <u>76</u> yrs. <u>5</u> mos. <u>27</u> ds.		If LESS than 1 day, _____ hrs. OR _____ min. ?	
8 OCCUPATION (a) Trade, profession, or particular kind of work <u>Housewife</u> (b) General nature of industry, business, or establishment in which employed (or employer) _____			
9 BIRTHPLACE (State or country) <u>va</u>			
PARENTS	10 NAME OF FATHER <u>Michael Long</u>		
	11 BIRTHPLACE OF FATHER (State or country) <u>va</u>		
	12 MAIDEN NAME OF MOTHER <u>Nellie Lilly</u>		
13 BIRTHPLACE OF MOTHER (State or country) <u>unknown</u>			
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Henry Long</u> (Address) <u>Brunswick Md</u>			
15 Filled <u>Jan 30</u> , 191 <u>4</u> <u>Emma S. Younkine</u> Deputy REGISTRAR			
MEDICAL CERTIFICATE OF DEATH			
16 DATE OF DEATH <u>Jan 29</u> , 191 <u>4</u> (Month) (Day) (Year)			
17 I HEREBY CERTIFY, That I attended deceased from <u>Jan 19</u> , 191 <u>4</u> , to <u>Jan 29</u> , 191 <u>4</u> , that I last saw him alive on <u>Jan 27</u> , 191 <u>4</u> , and that death occurred on the date stated above, at <u>10 A</u> m. The CAUSE OF DEATH* was as follows: <u>Broncho pneumonia</u>			
(Duration) _____ yrs. _____ mos. <u>5</u> ds.			
Contributory (Secondary) <u>La Grippe</u> (Duration) _____ yrs. _____ mos. <u>10</u> ds.			
(Signed) <u>AB Horine</u> , M. D. <u>Jan 29</u> , 191 <u>4</u> (Address) <u>Brunswick Md</u>			
*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.			
18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds. Where was disease contracted, if not at place of death? Former or usual residence _____			
19 PLACE OF BURIAL OR REMOVAL <u>Knoxville Md</u>		DATE OF BURIAL <u>Jan 31</u> , 191 <u>4</u>	
20 UNDERTAKER <u>Chas F. Frazier</u>		ADDRESS <u>Brunswick Md</u>	

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

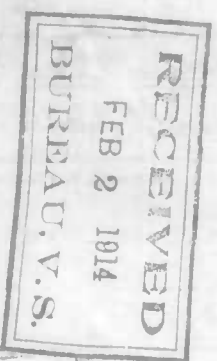
[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the ~~name~~ CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc. *Carcin-*

*oma*, *Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 *ds.*; *Bronchopneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and quality as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Retrover wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained by the certifier. The certificate is permanently filed.





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## PLACE OF DEATH

County

Village or City

## FULL NAME

## PERSONAL AND STATISTICAL PARTICULARS

SEX

COLOR OR RACE

SINGLE,  
MARRIED,  
WIDOWED,  
OR DIVORCED  
(Write the word)

DATE OF BIRTH

AGE

If LESS than  
1 day, .... hrs.  
OR, .... min. ?

OCCUPATION

(a) Trade, profession, or  
particular kind of work(b) General nature of industry,  
business, or establishment in  
which employed (or employer)BIRTHPLACE  
(State or country)NAME OF  
FATHERBIRTHPLACE  
OF FATHER  
(State or country)MAIDEN NAME  
OF MOTHERBIRTHPLACE  
OF MOTHER  
(State or country)

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Filed

REGISTRAR

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registered No.

[If death occurred in  
a hospital or institution,  
give its NAME instead  
of street and number.]

## MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH

I HEREBY CERTIFY, That I attended deceased from

that I last saw him alive on

and that death occurred on the date stated above, at, m.

The CAUSE OF DEATH\* was as follows:

Contributory  
(Secondary)

(Signed)

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT  
CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL,  
SUICIDAL, or HOMICIDAL.LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS,  
OR RECENT RESIDENTS)At place  
of death yrs. mos. ds. In the  
State yrs. mos. ds.

Where was disease contracted,

If not at place of death?

Former or  
usual residence

PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

UNDERTAKER

ADDRESS

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

Approved by U. S. Census and American Public Health Association. 1

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## PLACE OF DEATH

917

County WashingtonSTATE OF MARYLAND  
CERTIFICATE OF DEATHRegistered No. 302Village or City Hagerstown (No. 33 Elizabeth St; 2 Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

FULL NAME Dora Belle Imes

## PERSONAL AND STATISTICAL PARTICULARS

SEX Female COLOR OR RACE White SINGLE, MARRIED, WIDOWED, OR DIVORCED Married  
(Write the word)  
DATE OF BIRTH January 13, 1882  
(Month) (Day) (Year)  
AGE 32 yrs. 10 ds. OR min. ?

OCCUPATION  
(a) Trade, profession, or particular kind of work House Wife  
(b) General nature of industry, business, or establishment to which employed (or employer) .....

BIRTHPLACE  
(State or country) Green Ridge Md.

PARENTS  
10 NAME OF FATHER Peter Alderton  
11 BIRTHPLACE OF FATHER (State or country) Maryland  
12 MAIDEN NAME OF MOTHER Mazie Slider  
13 BIRTHPLACE OF MOTHER (State or country) Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Millard Imes33 Elizabeth St Hagerstown Md  
(Address)Filed 1/24, 1914 Henry Davis  
REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Jan 23, 1914  
(Month) (Day) (Year)17 I HEREBY CERTIFY, That I attended deceased from Jan 12, 1914 to Jan 23, 1914  
that I last saw him alive on Jan 23, 1914and that death occurred on the date stated above, at 4:30 m.  
The CAUSE OF DEATH\* was as follows:Abortion and Peritonitis(Duration) 10 yrs. 10 mos. 10 ds.Contributory (Secondary) Septicemia(Duration) 2 yrs. 2 mos. 2 ds.(Signed) Dr. J. S. Rogers M. D.  
1/23, 1914 (Address) Hagerstown

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.Where was disease contracted, If not at place of death? .....Former or usual residence .....19 PLACE OF BURIAL OR REMOVAL Rose Hill Hagerstown Md. DATE OF BURIAL Jan. 24, 191420 UNDERTAKER S.K. Lowman Hagerstown Md. ADDRESS .....

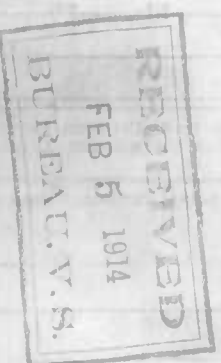
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**1 PLACE OF DEATH** 918  
 County Washington  
 Village or City Clear Spring (No. \_\_\_\_\_) St.; \_\_\_\_\_ Ward) [If death occurred in a hospital or institution, give its NAME instead of street and number.]  
**2 FULL NAME** Pauline R. Leasher

Registration Dist. No. 303

## PERSONAL AND STATISTICAL PARTICULARS

**3 SEX** Female **4 COLOR OR RACE** White **5 SINGLE, MARRIED, WIDOWED, OR DIVORCED** (Write the word) \_\_\_\_\_  
**6 DATE OF BIRTH** Jan. 7, 1914  
 (Month) (Day) (Year)  
**7 AGE** (Still-Born) It LESS than 1 day, \_\_\_\_\_ hrs. yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. OR \_\_\_\_\_ min. ?

**8 OCCUPATION**  
 (a) Trade, profession, or particular kind of work None  
 (b) General nature of industry, business, or establishment in which employed (or employer) \_\_\_\_\_

**9 BIRTHPLACE** (State or country) Washington, D.C.

**PARENTS**  
**10 NAME OF FATHER** Fred Leasher  
**11 BIRTHPLACE OF FATHER** (State or country) Clear Spring, Md.  
**12 MAIDEN NAME OF MOTHER** Lilly Brewer  
**13 BIRTHPLACE OF MOTHER** (State or country) Clear Spring, Md.

**14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE**

(Informant) \_\_\_\_\_  
 (Address) Fredrick H. Leasher-Clear Spring

**15** Jan 7, 1914 Doris S. Miller  
 Filed \_\_\_\_\_ REGISTRAR

STATE OF MARYLAND  
CERTIFICATE OF DEATH

## MEDICAL CERTIFICATE OF DEATH

**16 DATE OF DEATH** January 7, 1914  
 (Month) (Day) (Year)

**17 I HEREBY CERTIFY, That I attended deceased from** January 7, 1914 to \_\_\_\_\_, 1914.

that I last saw him/her alive on \_\_\_\_\_, 1914.

and that death occurred on the date stated above, at \_\_\_\_\_ m.

The CAUSE OF DEATH\* was as follows:

Still Born Child.

(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Contributory  
 Secondary

(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

(Signed) Jonathan P. Perry, M. D.  
Jan 7, 1914 (Address) Clear Spring, Md.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

**18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)**

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. In the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Where was disease contracted, If not at place of death?

Former or usual residence \_\_\_\_\_

**19 PLACE OF BURIAL OR REMOVAL** St. Pauls **DATE OF BURIAL** Jan 7, 1914

**20 UNDERTAKER** Frank Brown & Co **ADDRESS** Clear Spring



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

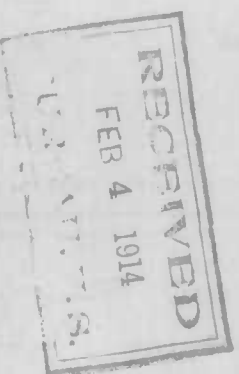
[Approved by U. S. Census and American Public Health Association.]

**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc., *Carcin-*

*oma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

919

County

Washington

Village or City

Charlton

(No.

Registration Dist. No. 303

St.; Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

Hester Estelle Leasure

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female White

4 COLOR OR RACE

5 SINGLE,

MARRIED,

WIDOWED,

OR DIVORCED

(Write the word)

Single

6 DATE OF BIRTH

Jan 5, 1907

(Month)

(Day)

(Year)

7 AGE

7 yrs 0 mos 19 ds.

If LESS than  
1 day, hrs.  
OR min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE  
(State or country)

Washington Co Md

PARENTS

10 NAME OF FATHER

Harry S. Leasure

11 BIRTHPLACE OF FATHER  
(State or country)

Berkley Co W. Va

12 MAIDEN NAME OF MOTHER

Nellie Lumpower

13 BIRTHPLACE OF MOTHER  
(State or country)

Washington Co Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Harry S. Leasure

(Address)

Charlton Md.

15

Filed

Jan 26, 1914 David S. Miller

REGISTRAR

STATE OF MARYLAND  
CERTIFICATE OF DEATH

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

1 - 24, 1914

(Month)

(Day)

(Year)

17

I HEREBY CERTIFY, That I attended deceased from

Jan. 22, 1914, to Jan. 24, 1914,

that I last saw him alive on Jan. 24, 1914,

and that death occurred on the date stated above, at 8:30 P. M.

The CAUSE OF DEATH\* was as follows:

acute meningitis.

(Duration) yrs. mos. 4 ds.

Contributory  
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

Thos. Boose

M. D.

Jan 26, 1914 (Address) Winesport, Md.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

St Pauls Cemetery

Jan 27, 1914

20 UNDERTAKER

ADDRESS

Franz Boose &amp; Co Clear Spring

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto. Requesting V. S. No. 1.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry; and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc.. *Carcin-*

*oma*, *Sarcoma*, etc., of \_\_\_\_\_ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Anemia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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PLACE OF DEATH

920

County Washington

Village or City Hagerstown (No. 71 Madison Ave. St; 2 Ward)

FULL NAME William E. Little

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registered No. 302

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

PERSONAL AND STATISTICAL PARTICULARS

SEX Male COLOR OR RACE White SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Single

DATE OF BIRTH January 13 1892  
(Month) (Day) (Year)

AGE 22 yrs. 13 mos. 13 ds. If LESS than 1 day, hrs. OR min. ?

OCCUPATION  
(a) Trade, profession, or particular kind of work Machinist  
(b) General nature of industry, business, or establishment in which employed (or employer) Wood

BIRTHPLACE (State or country) Petersville Md.

NAME OF FATHER John E. Little

BIRTHPLACE OF FATHER (State or country) Burkittsville Md.

MAIDEN NAME OF MOTHER Florence C. Hutts

BIRTHPLACE OF MOTHER (State or country) Knoxville Md.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) John E. Little  
71 Madison Ave Hagerstown  
(Address)

Filed 1/28 1914 Henry Davis  
REGISTRAR

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Jan 26, 1914  
(Month) (Day) (Year)

I HEREBY CERTIFY That I attended deceased from Sept 26, 1914 to Jan 26, 1914

that I last saw him alive on Jan 24, 1914

and that death occurred on the date stated above, at 10 P. m.

The CAUSE OF DEATH\* was as follows:

Pulmonary tuberculosis

(Duration) 1 yrs. 4 mos. 1 ds.  
Contributory (Secondary) Cardiac asthma

(Duration) 7 yrs. 7 mos. 7 ds.  
(Signed) E. J. Tetter, M. D.  
Jan 27, 1914 (Address) Hagerstown, Md.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death 7 yrs. 7 mos. 7 ds. In the State 7 yrs. 7 mos. 7 ds.

Where was disease contracted, if not at place of death?  
Former or usual residence.

PLACE OF BURIAL OR REMOVAL Rose Hill Hagerstown Md. DATE OF BURIAL Jan 29, 1914

UNDERTAKER S. K. Lowman Hagerstown Md. ADDRESS

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

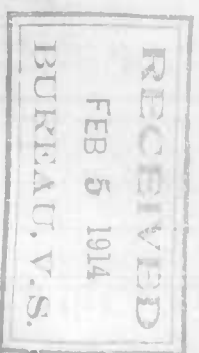
Approved by U. S. Census and American Public Health Association.]

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*oma*, *Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congestital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Træmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and quality as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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921

## 1 PLACE OF DEATH

County

*Washington*

Village or City

*Hagerstown*

(No.)

*Security*

St.; — Ward)

## 2 FULL NAME

*Robert G. Long*STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No.

*302*

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Male* 4 COLOR OR RACE *White* 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED *Widow*  
(Write the word)

6 DATE OF BIRTH

*9**8**1850*

(Month)

(Day)

(Year)

7 AGE

*64*

yrs.

*4*

mos.

*18*

ds.

If LESS than

1 day, .... hrs.

OR .... min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work

*Laborer*

(b) General nature of industry, business, or establishment in which employed (or employer)

*(1)*

9 BIRTHPLACE

(State or country)

*Md*

PARENTS

10 NAME OF FATHER

*don't know*

11 BIRTHPLACE OF FATHER

(State or country)

*don't know*

12 MAIDEN NAME OF MOTHER

*don't know*

13 BIRTHPLACE OF MOTHER

(State or country)

*don't know*

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

*Susan Bideman*

(Address)

*Security Md*

15

Filed

*1/28*

1914

*Henry Davis*

REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

*1**27**1914*

(Month)

(Day)

(Year)

17

I HEREBY CERTIFY, That I attended deceased from

*1/23*

1914, to

*1/25*

1914,

that I last saw him alive on

*1/25*

1914

and that death occurred on the date stated above, at *2:30 p.m.*

The CAUSE OF DEATH\* was as follows:

*cerebral hemorrhage*

(Duration)

yrs.

mos.

ds.

Contributory  
Secondary

(Duration)

yrs.

mos.

ds.

(Signed)

*V. E. Dwyer Jr.*

, M. D.

*1/27*

1914.

(Address)

*Hagerstown*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place

of death

yrs.

mos.

ds.

In the

State

yrs.

mos.

ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

*Shilo**1/29*

1914

20 UNDERTAKER

ADDRESS

*Watkins & Minnick**Hag. Md.*

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

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[Approved by U. S. Census and American Public Health Association.]

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*oma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Con-renal," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Maras-mus," "Old Age," "Shock," "Traemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septichaemia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For vio-lent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—ac-cident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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RECEIVED  
FEB 5 1914  
BUREAU, U. S.

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1 PLACE OF DEATH 922  
County Washington

Village or City Dauessville (No. \_\_\_\_\_)

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 311

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Simon Lang

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDDED, OR DIVORCED Widower  
(Write the word)

6 DATE OF BIRTH

7 (Month) 17 (Day) 1886 (Year)

7 AGE

87 yrs. 5 mos. 17 ds. If LESS than 1 day, \_\_\_\_ hrs. OR \_\_\_\_ min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work Retired Farmer  
(b) General nature of industry, business, or establishment in which employed (or employer) \_\_\_\_\_

9 BIRTHPLACE (State or country)

Maryland

PARENTS

10 NAME OF FATHER

Isaac Lang

11 BIRTHPLACE OF FATHER (State or country)

Maryland

12 MAIDEN NAME OF MOTHER

Elizabeth Lifer

13 BIRTHPLACE OF MOTHER (State or country)

Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) McBellan Long

(Address) Fairplay Md.

15

Filed Jan 5, 1914 V. M. Reichard Local REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Jan 4, 1914  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Nov 25, 1913, to Jan 4, 1914,

that I last saw him alive on Jan 4, 1914,

and that death occurred on the date stated above, at 12:45 P.M.

The CAUSE OF DEATH\* was as follows:

Gastro-Enteritis

Contributory Secondary

(Duration) 15 yrs. 1 mos. 1 ds.

(Signed) V. M. Reichard, M. D.  
Jan 5, 1914 (Address) Fair Play Md

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds. In the State \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Where was disease contracted, if not at place of death?

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Manor Cemetery

Jan 7, 1914

20 UNDERTAKER

ADDRESS

V. M. Reichard

Fairplay, Md.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

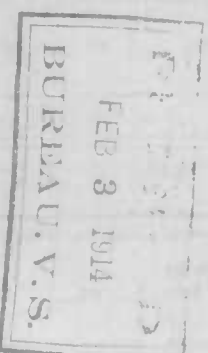
[Approved by U. S. Census and American Public Health Association.]

**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Plumber*, *Physician*, *Composer*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Fireman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not faintly employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

*oma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congestant," "Scnlie," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH County <u>Washington</u> 923			STATE OF MARYLAND CERTIFICATE OF DEATH		
Village or City <u>District #5</u> (No. <u>5</u> )			Registered No. <u>304</u>		
2 FULL NAME <u>John M. Custer</u>					
PERSONAL AND STATISTICAL PARTICULARS					
3 SEX <u>Male</u>	4 COLOR OR RACE <u>White</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED <u>Married</u> (Write the word)			
6 DATE OF BIRTH <u>Oct 29</u> , 18 <u>46</u> (Month) (Day) (Year)					
7 AGE <u>67</u> yrs. <u>2</u> mos. <u>1</u> ds. <input checked="" type="checkbox"/> If LESS than 1 day, hrs. <u>1</u> OR min. ?					
8 OCCUPATION (a) Trade, profession, or particular kind of work <u>Farmer</u> (b) General nature of industry, business, or establishment in which employed (or employer)					
9 BIRTHPLACE (State or country) <u>Penn.</u>					
PARENTS					
10 NAME OF FATHER <u>John M. Custer</u>					
11 BIRTHPLACE OF FATHER (State or country) <u>Ireland</u>					
12 MAIDEN NAME OF MOTHER <u>Sarah Bishop</u>					
13 BIRTHPLACE OF MOTHER (State or country) <u>Penn.</u>					
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>George M. Custer</u> (Address) <u>Hancock Md.</u>					
15 Filed <u>1/12</u> , 191 <u>4</u> <u>C. J. M. [Signature]</u> REGISTRAR					
MEDICAL CERTIFICATE OF DEATH					
16 DATE OF DEATH <u>Jan 12</u> , 191 <u>4</u> (Month) (Day) (Year)					
17 I HEREBY CERTIFY, That I attended deceased from <u>Jan. 9</u> , 191 <u>4</u> , to <u>Jan 12</u> , 191 <u>4</u> , that I last saw him alive on <u>Jan 12</u> , 191 <u>4</u> , and that death occurred on the date stated above, at <u>1 A</u> m. The CAUSE OF DEATH* was as follows: <u>Lobar Pneumonia</u> (Duration) yrs. <u>4</u> mos. <u>4</u> ds. Contributory (Secondary) (Duration) yrs. <u>4</u> mos. <u>4</u> ds. (Signed) <u>J. H. Mc. [Signature]</u> , M. D. <u>Jan 12</u> , 191 <u>4</u> (Address) <u>Buck Valley Pa</u> *State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, OR HOMICIDAL.					
18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death yrs. <u>4</u> mos. <u>4</u> ds. In the State yrs. <u>4</u> mos. <u>4</u> ds. Where was disease contracted, If not at place of death? Former or usual residence					
19 PLACE OF BURIAL OR REMOVAL <u>Hancock Md.</u> DATE OF BURIAL <u>Jan 13</u> , 191 <u>4</u>					
20 UNDERTAKER <u>M. J. [Signature]</u> ADDRESS <u>Hancock Md.</u>					

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

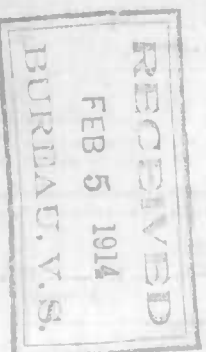
[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Composer*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc. *Carcin-*

*oma*, *Sarcoma*, etc., of \_\_\_\_\_ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *10 ds.* Never report *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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PLACE OF DEATH

924

County WashingtonSTATE OF MARYLAND  
CERTIFICATE OF DEATHRegistered No. 302Village or City Hagerstown (No. Bellevue St.; Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

FULL NAME Sarah E. Maloy

## PERSONAL AND STATISTICAL PARTICULARS

SEX Female COLOR OR RACE White SINGLE, MARRIED, WIDOWED, OR DIVORCED Married  
(Write the word)

DATE OF BIRTH March 12, 1827  
(Month) (Day) (Year)

AGE 86 yrs. 10 mos. 11 ds. IF LESS than 1 day, hrs. OR min. ?

OCCUPATION  
(a) Trade, profession, or particular kind of work House Work  
(b) General nature of industry, business, or establishment in which employed (or employer) —

BIRTHPLACE (State or country) PennsylvaniaPARENTS  
10 NAME OF FATHER Daniel Maloy11 BIRTHPLACE OF FATHER (State or country) Pennsylvania12 MAIDEN NAME OF MOTHER Mary Schoeffler13 BIRTHPLACE OF MOTHER (State or country) Pennsylvania

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Elmer E. Maloy  
(Address) Hagerstown Md

15 Filed 1/20, 1914 Henry Davis  
REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH January 19, 1914  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Nov 17, 1913 to January 19, 1914

that I last saw him alive on July 16, 1914

and that death occurred on the date stated above, at 3 a.m.

The CAUSE OF DEATH\* was as follows:

old age

(Duration) yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) George S. Evershart, M. D.

January 19, 1914 (Address) 27 W. Franklin St. Hagerstown Md

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. 2 mos. ds. In the State 15 yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence Pearsons, Md

19 PLACE OF BURIAL OR REMOVAL Cypress Hill Pa DATE OF BURIAL Jan 20, 1914

20 UNDERTAKER H. Lippman ADDRESS Hagerstown Md

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

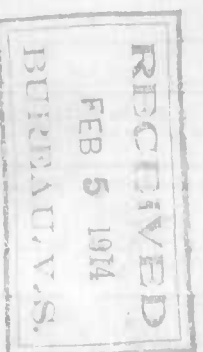
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**Statement of cause of death**—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc.. *Carcin-*

*oma*, *Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 *ds.*; *Bronchopneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Traemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH **925**  
 County Washington  
 Village or City Funkstown (No. 50) St. \_\_\_\_\_ Ward) \_\_\_\_\_  
 Registration Dist. No. 309

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Edward W. Marteny

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Married  
 (Write the word)

6 DATE OF BIRTH 3 7 1872  
 (Month) (Day) (Year)

7 AGE 41 yrs. 3 mos. 5 ds. If LESS than 1 day, \_\_\_\_\_ hrs. OR \_\_\_\_\_ min. ?

8 OCCUPATION  
 (a) Trade, profession, or particular kind of work Butcher  
 (b) General nature of industry, business, or establishment in which employed (or employer) \_\_\_\_\_

9 BIRTHPLACE (State or country) Tilmanston, Md.

PARENTS  
 10 NAME OF FATHER Jacob Marteny  
 11 BIRTHPLACE OF FATHER (State or country) Brownboro  
 12 MAIDEN NAME OF MOTHER Adaline Reed  
 13 BIRTHPLACE OF MOTHER (State or country) Unknown

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. E. Marteny  
 (Address) Funkstown

15 Filed Jan 15, 1914 M. L. Miller  
 REGISTRAR

STATE OF MARYLAND  
CERTIFICATE OF DEATH

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH 1 12 1914  
 (Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from July 1st, 1912, to Jan 1914,  
 that I last saw him alive on January 12, 1914

and that death occurred on the date stated above, at 4:30 P. M.  
 The CAUSE OF DEATH\* was as follows:

Diabetes

(Duration) 10 yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.  
 Contributory General Toxemia  
 Secondary \_\_\_\_\_

(Signed) [Signature] (Duration) 5 mos. \_\_\_\_\_ ds.  
3, 1914 (Address) [Signature], M. D.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. In the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Where was disease contracted, If not at place of death? \_\_\_\_\_

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL Funkstown DATE OF BURIAL Jan 15, 1914

20 UNDERTAKER L. F. Reicher ADDRESS Funkstown

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

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**Statement of cause of death**—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tubercleis of lungs*, *meninges*, *peritonaeum*, etc., *Carcin-*

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FEB 7 1914  
BUREAU U. S.

oma, Sarcoma, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-theia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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RECEIVED  
MAR 27 1914  
BUREAU U. S.

Orig. and in pencil



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PLACE OF DEATH

926

County WashingtonSTATE OF MARYLAND  
CERTIFICATE OF DEATHRegistered No. 302Village or City Hagerstown Md. (No. Funkstown Pike Edge city Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

FULL NAME Theodore C. Martz

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX <u>Male</u>	4 COLOR OR RACE <u>White</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <u>Married</u>
6 DATE OF BIRTH <u>September 7, 1858</u> (Month) (Day) (Year)		
7 AGE <u>55</u> yrs. <u>4</u> mos. <u>11</u> ds. <u>11</u> LESS than 1 day, .... hrs. OR .... min. ?		

8 OCCUPATION  
(a) Trade, profession, or particular kind of work. Carpenter  
(b) General nature of industry, business, or establishment in which employed (or employer) House Carpenter

9 BIRTHPLACE  
(State or country) Boonsboro Md.

PARENTS	10 NAME OF FATHER <u>David Martz</u>
	11 BIRTHPLACE OF FATHER (State or country) <u>Rohrersville Md</u>
	12 MAIDEN NAME OF MOTHER <u>Mahala Reeder</u>
	13 BIRTHPLACE OF MOTHER (State or country) <u>Rohrersville Md.</u>

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs Lena Martz  
(Address) Hagerstown Md

15 Filed 1/21-, 1914 Henry Davis  
REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH January 18, 1914  
(Month) (Day) (Year)17 I HEREBY CERTIFY, That I attended deceased from Dec 1, 1913 to January 18, 1914that I last saw him alive on January 18, 1914and that death occurred on the date stated above, at 10 P. m.

The CAUSE OF DEATH\* was as follows:

Pulmonary Tuberculosis(Duration) 7 yrs. 7 mos. X ds.Contributory (Secondary) Coronary Failure(Duration) X yrs. 2 mos. X ds.(Signed) J. H. Dugan, M. D.Jan 21, 1914 (Address) Hagerstown Md

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, OF HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death .... yrs. .... mos. .... ds. In the State .... yrs. .... mos. .... ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Md. DATE OF BURIALRose Hill Hagerstown Jan. 21 1914

20 UNDERTAKER ADDRESS

S. K. Lowman Hagerstown Md.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

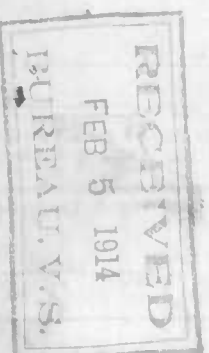
[Approved by U. S. Census and American Public Health Association.]

**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Composer*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not faithfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc.. *Carcin-*

*oma*, *Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 19 &c.; *Bronchopneumonia* (secondary), 10 &c. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

927

County

Washington

Village or City

Hagerstown

(No. 338)

Registration Dist. No.

302

St. 4 Ward

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

Mary Elizabeth Miller

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

female

4 COLOR OR RACE

white

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED

Widowed

6 DATE OF BIRTH

Feb

7

1881

(Month)

(Day)

(Year)

7 AGE

12 yrs.

11 mos.

13 ds.

If LESS than  
1 day, .... hrs.  
OR .... min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work

Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE

(State or country)

Md

PARENTS

10 NAME OF FATHER

Andrew French

11 BIRTHPLACE OF FATHER

(State or country)

Md.

12 MAIDEN NAME OF MOTHER

Anna Ridenour

13 BIRTHPLACE OF MOTHER

(State or country)

Md.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Miss Anna Miller

(Address)

Hagerstown Md.

15

Filed

1/20, 1914

Harry Davis

REGISTRAR

STATE OF MARYLAND  
CERTIFICATE OF DEATH

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

1

20

1914

(Month)

(Day)

(Year)

17

I HEREBY CERTIFY, That I attended deceased from

1/17

1914

to

1/19

1914

that I last saw him alive on

1/19

1914

and that death occurred on the date stated above, at 3 a. m.

The CAUSE OF DEATH\* was as follows:

Influenza 3 a  
Cholelithiasis  
10

(Duration)

yrs.

mos.

3 ds.

Contributory  
Secondary

(Duration)

yrs.

mos.

ds.

(Signed)

Victor Smith

M. D.

1/20

1914

(Address)

Hagerstown Md

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place

of death

yrs.

mos.

ds.

In the

State

yrs.

mos.

ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Smithsburg

1/22

1914

20 UNDERTAKER

ADDRESS

Watkins Minnick

Hagerstown Md

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

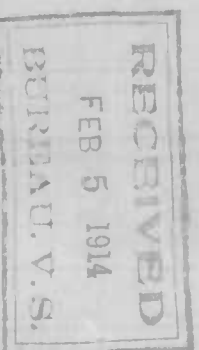
[Approved by U. S. Census and American Public Health Association.]

**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meningis, peritonaeum*, etc., *Carcin-*

*oma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection used not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Reverber wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



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## PLACE OF DEATH

928

STATE OF MARYLAND  
CERTIFICATE OF DEATHCounty WashingtonRegistered No. 302Village or City Hagerstown (No. 117 East Ave St; 4 Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

FULL NAME

(Still Born)

Murphy

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Single

6 DATE OF BIRTH January 28, 1914  
(Month) (Day) (Year)

7 AGE 11 LESS than 1 day, ..... hrs. OR ..... min. ?  
..... yrs. .... mos. .... ds.

8 OCCUPATION  
(a) Trade, profession, or particular kind of work None  
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9 BIRTHPLACE (State or country) Hagerstown Md.

10 NAME OF FATHER Frank R. Murphy

11 BIRTHPLACE OF FATHER (State or country) Warren Co., Va.

12 MAIDEN NAME OF MOTHER Mamie E. Supinger

13 BIRTHPLACE OF MOTHER (State or country) Strawburg VA.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Frank R. Murphy117 (Address) East Ave Hagerstown Md

15 Filed 1/30, 1914 Henry Davis  
REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Jan 28, 1914  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Jan 28, 1914 to Jan 28, 1914  
that I last saw him alive on Still Born, 1914

and that death occurred on the date stated above, at 3:45 P m.  
The CAUSE OF DEATH\* was as follows:

Unknown

Contributory (Secondary) ..... (Duration) ..... yrs. .... mos. .... ds.

(Signed) W. S. Supp M. D.  
1/30, 1914 (Address) Hagerstown

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ..... yrs. .... mos. .... ds. In the State ..... yrs. .... mos. .... ds.

Where was disease contracted, If not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Rose Hill Hagerstown Md Jan 30, 1914

20 UNDERTAKER ADDRESS

S. K. Lowman Hagerstown Md.



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

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## PLACE OF DEATH

929

County WashingtonSTATE OF MARYLAND  
CERTIFICATE OF DEATHRegistered No. 302Village or City Hagerstown (No. Hamilton Lane St. 5 Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

FULL NAME Leri Pze

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE Colored 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Widower  
(Write the word)

6 DATE OF BIRTH Feb 18, 1897  
(Month) (Day) (Year)

7 AGE 76 yrs. 10 mos. 29 ds. 11 LESS than 1 day, hrs. OR min.?

8 OCCUPATION (a) Trade, profession, or particular kind of work Laborer  
(b) General nature of industry, business, or establishment in which employed (or employer) C

9 BIRTHPLACE (State or country) Maryland

10 NAME OF FATHER Escar Pzi

11 BIRTHPLACE OF FATHER (State or country) Virginia

12 MAIDEN NAME OF MOTHER Katharine Hanna

13 BIRTHPLACE OF MOTHER (State or country) Virginia

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Albert Reed

(Address) Hagerstown Md

15 Filed 1/18, 1914 Hemp Davis  
REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Jan 17, 1914  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, that I attended deceased from Jan 16, 1914 to Jan 17, 1914

that I last saw him alive on Jan 16, 1914

and that death occurred on the date stated above, at 7:30 P. m.

The CAUSE OF DEATH\* was as follows:

arterio-sclerosis  
(Duration) ? yrs. mos. ds.

Contributory (Secondary) arterio-sclerosis  
(Duration) ? yrs. mos. ds.

(Signed) J. P. Hough, M. D.  
191 (Address)

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Calverton DATE OF BURIAL Jan 19, 1914

20 UNDERTAKER H. Coffman ADDRESS Hagerstown

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

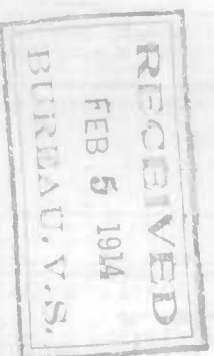
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*oma, Sarcoma*, etc., of \_\_\_\_\_ (name organ; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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**1 PLACE OF DEATH** 930  
 County Washington  
 Village or City Charlton (No. 170) St.; Ward)  
**2 FULL NAME** Miss Rachel M. Renner

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

Registration Dist. No. 303

## PERSONAL AND STATISTICAL PARTICULARS

**3 SEX** Female  
**4 COLOR OR RACE** White  
**5 SINGLE, MARRIED, WIDOWED, OR DIVORCED** Single  
 (Write the word)  
**6 DATE OF BIRTH** April 6, 1853  
 (Month) (Day) (Year)  
**7 AGE** 60 yrs. 9 mos. 13 ds. If LESS than 1 day, .... hrs. OR .... min. ?

**8 OCCUPATION**  
 (a) Trade, profession, or particular kind of work At Home  
 (b) General nature of industry, business, or establishment in which employed (or employer)

**9 BIRTHPLACE** (State or country) Maryland

**PARENTS**  
**10 NAME OF FATHER** John W. Renner  
**11 BIRTHPLACE OF FATHER** (State or country) Smithsburg Md.  
**12 MAIDEN NAME OF MOTHER** Matilda Mehard  
**13 BIRTHPLACE OF MOTHER** (State or country) Waynesboro Pa.

**14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE**  
 (Informant) Lewis L. Renner  
 (Address) Charlton Md.

**15** Filed July 19<sup>th</sup>, 1914 David S. Miller  
 REGISTRAR

STATE OF MARYLAND  
CERTIFICATE OF DEATH

## MEDICAL CERTIFICATE OF DEATH

**16 DATE OF DEATH** Jan. 18, 1914  
 (Month) (Day) (Year)

**17 I HEREBY CERTIFY**, That I attended deceased from Nov. 14, 1913, to Jan 18, 1914,  
 that I last saw her alive on Jan 18, 1914.

and that death occurred on the date stated above, at 2 P. m.  
 The CAUSE OF DEATH\* was as follows:

Chronic Nephritis

(Duration) 2 yrs. .... mos. .... ds.

Contributory  
 Secondary

(Signed) H. C. Foster, M. D.  
Jan. 19, 1914 (Address) Charespring Ind.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

**18 LENGTH OF RESIDENCE** (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death .... yrs. .... mos. .... ds. In the State .... yrs. .... mos. .... ds.

Where was disease contracted,  
 If not at place of death?

Former or usual residence

**19 PLACE OF BURIAL OR REMOVAL** St Pauls Cemetery **DATE OF BURIAL** Jan 20, 1914

**20 UNDERTAKER** Frank B. Co Clear Spring  
 ADDRESS

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

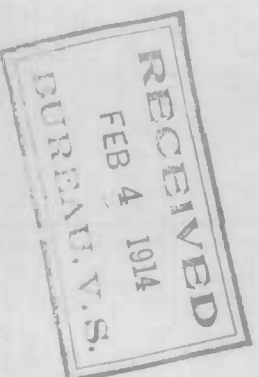
[Approved by U. S. Census and American Public Health Association.]

**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Former (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum*, etc., *Carcin-*

*oma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic tubular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Ivanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PREPERAL septicæmia," "PREPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.





WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH		STATE OF MARYLAND	
County <u>Worthington</u>		CERTIFICATE OF DEATH	
Village or City <u>Hagerstown</u>		Registered No. <u>302</u>	
(No. <u>114</u> <u>Blooms ally</u> St; <u>5<sup>th</sup></u> Ward)		[If death occurred in a hospital or institution, give its NAME instead of street and number.]	
2 FULL NAME <u>Catharine Reynolds</u>			
PERSONAL AND STATISTICAL PARTICULARS			
3 SEX <u>Female</u>	4 COLOR OR RACE <u>Colored</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED <u>married</u> (Write the word)	
6 DATE OF BIRTH <u>6th</u> <u>24</u> <u>1872</u> (Month) (Day) (Year)			
7 AGE <u>41</u> yrs. <u>3</u> mos. <u>2</u> ds. <u>OR</u> <u>1</u> day <u>1</u> hrs. <u>OR</u> <u>1</u> min. ? If LESS than 1 day, hrs. or min. ?			
8 OCCUPATION (a) Trade, profession, or particular kind of work <u>House Work</u> (b) General nature of industry, business, or establishment in which employed (or employer) <u>—</u>			
9 BIRTHPLACE (State or country) <u>Virginia</u>			
PARENTS	10 NAME OF FATHER <u>Samuel Weaver</u>		
	11 BIRTHPLACE OF FATHER (State or country) <u>Virginia</u>		
	12 MAIDEN NAME OF MOTHER <u>Kennie Taylor</u>		
13 BIRTHPLACE OF MOTHER (State or country) <u>Virginia</u>			
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>James Reynolds</u> (Address) <u>Coyestown Md</u>			
15 Filed <u>1/27<sup>th</sup></u> <u>1914</u> <u>Henry Davis</u> REGISTRAR			
MEDICAL CERTIFICATE OF DEATH			
16 DATE OF DEATH <u>Jan. 27</u> <u>1914</u> (Month) (Day) (Year)			
17 I HEREBY CERTIFY, That I attended deceased from <u>Jan. 1</u> <u>1914</u> to <u>Jan. 26</u> <u>1914</u> that I last saw her alive on <u>Jan 26</u> <u>1914</u> and that death occurred on the date stated above, at <u>8 a.</u> m. The CAUSE OF DEATH* was as follows: <u>Bulbar Paralysis</u> (Duration) <u>2</u> yrs. <u>—</u> mos. <u>—</u> ds. Contributory (Secondary) <u>Exhaustion</u> (Duration) <u>—</u> yrs. <u>—</u> mos. <u>—</u> ds. (Signed) <u>Allen B. Wilson</u> M. D. <u>Jan. 28</u> <u>1914</u> (Address) <u>Hagerstown Md</u> *State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. 18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death <u>—</u> yrs. <u>—</u> mos. <u>—</u> ds. In the State <u>—</u> yrs. <u>—</u> mos. <u>—</u> ds. Where was disease contracted, if not at place of death? Former or usual residence <u>—</u> 19 PLACE OF BURIAL OR REMOVAL <u>Hagerstown Md</u> DATE OF BURIAL <u>Jan 28</u> <u>1914</u> 20 UNDERTAKER <u>AK Coffman</u> ADDRESS <u>Hagerstown Md</u>			

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Composer*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Saleman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc.. *Carcin-*

*oma*, *Sarcoma*, etc., of \_\_\_\_\_ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 *ds.*; *Bronchopneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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RECEIVED  
FEB 5 1914  
BUREAU, V.S.

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1 PLACE OF DEATH

932

County

Village or City

(No.)

Registration Dist. No.

St.; Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)

married

6 DATE OF BIRTH

3

12

1838

(Month)

(Day)

(Year)

7 AGE

75

yrs.

10

mos.

8

ds.

If LESS than 1 day, hrs. OR min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work

Farmer

(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country)

Greensburg

## PARENTS

10 NAME OF FATHER

Henry B. Reynolds

11 BIRTHPLACE OF FATHER (State or country)

Doubt. know

12 MAIDEN NAME OF MOTHER

Margaret Ridmon

13 BIRTHPLACE OF MOTHER (State or country)

Near Greensburg

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

Informant)

H. B. Reynolds

(Address)

Smithsburg Md

15

Filed

January 1, 1914

J. H. Ferguson

REGISTRAR

STATE OF MARYLAND  
CERTIFICATE OF DEATH

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Jan 20<sup>th</sup>, 1914

(Month)

(Day)

(Year)

17

I HEREBY CERTIFY, That I attended deceased from Oct 1912, to Jan 18<sup>th</sup> 1914that I last saw him alive on Jan 18<sup>th</sup> 1914

and that death occurred on the date stated above, at 3 o'clock P. M.

The CAUSE OF DEATH\* was as follows:

Chronic nephritis

(Duration) 3 yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed)

Joseph P. Rothman, M. D.  
Smithsburg, Maryland.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Leamtown Md Jan 22<sup>nd</sup> 1914

20 UNDERTAKER

ADDRESS

Geo. B. Hoover Smithsburg Md

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

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**Statement of cause of death**—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc.. *Carcin-*

*oma*, *Sarcoma*, etc., of \_\_\_\_\_ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asphyxia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septicemia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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FEB 5 1914

BUREAU, U. S.

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1 PLACE OF DEATH  
County Washington 933  
Village or City Williamsport (No. 42) St.          Ward           
2 FULL NAME Ellen E Rhidmore  
Registered No. 301  
[If death occurred in a hospital or institution, give its NAME instead of street and number.]

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female  
4 COLOR OR RACE White  
5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Child  
6 DATE OF BIRTH July 31, 1913  
(Month) (Day) (Year)  
7 AGE 3 yrs. 27 mos. 27 ds. If LESS than 1 day,          hrs. OR          min. ?  
8 OCCUPATION (a) Trade, profession, or particular kind of work Child  
(b) General nature of industry, business, or establishment in which employed (or employer) Child

9 BIRTHPLACE (State or country) Maryland  
10 NAME OF FATHER Carol W Rhidmore  
11 BIRTHPLACE OF FATHER (State or country) Maryland  
12 MAIDEN NAME OF MOTHER Lida May Murton  
13 BIRTHPLACE OF MOTHER (State or country) Pennsylvania

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE  
(Informant) Ellen Stratiff  
(Address) Williamsport Md.

15 Filed Jan 28, 1914 C. E. Rickard  
Local REGISTRAR

STATE OF MARYLAND  
CERTIFICATE OF DEATH

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Jan 27, 1914  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Jan 24, 1914, to Jan 27, 1914,  
that I last saw her alive on Jan 27, 1914  
and that death occurred on the date stated above, at 6 P. m.  
The CAUSE OF DEATH\* was as follows:  
Acute Lobar Pneumonia  
(Duration)          yrs. 20 mos.          ds.  
Contributory (Secondary) Decubum of Lung  
(Duration)          yrs. 2 mos.          ds.  
(Signed) W. Richardson, M. D.  
Jan 28, 1914 (Address) Williamsport Md

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)  
At place of death          yrs.          mos.          ds. In the State          yrs.          mos.          ds.  
Where was disease contracted, If not at place of death?  
Former or usual residence         

19 PLACE OF BURIAL OR REMOVAL Williamsport Md DATE OF BURIAL Jan 29, 1914  
20 UNDERTAKER Leois W. Kups ADDRESS Williamsport Md



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

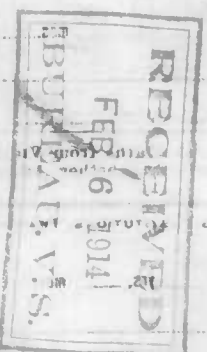
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**Statement of cause of death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*; *meninges*, *peritonaeum*, etc. *Carcin-*

*oma*, *Sarcoma*, etc., of \_\_\_\_\_ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic tubercular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary) *± 10 ds.* Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Hantion," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septicaemia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and quality, as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such. If impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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## 1 PLACE OF DEATH

County

Washington 934

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registered No. 310

Village or City

Wheaton (No. 66)

St.; Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

## 2 FULL NAME

George H. Rickards

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

Male

## 4 COLOR OR RACE

White

5 SINGLE,  
MARRIED,  
WIDOWED,  
OR DIVORCED  
(Write the word)

Married

## 6 DATE OF BIRTH

8 10, 1880  
(Month) (Day) (Year)

## 7 AGE

83 yrs. 5 mos. 11 ds. It LESS than 1 day, hrs. OR min. ?

## 8 OCCUPATION

(a) Trade, profession, or particular kind of work

Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE  
(State or country)

Maryland

## 10 NAME OF FATHER

Unknown

11 BIRTHPLACE OF FATHER  
(State or country)

Unknown

## 12 MAIDEN NAME OF MOTHER

Unknown

13 BIRTHPLACE OF MOTHER  
(State or country)

Unknown

## 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

George H. Rickards

(Address)

Wheaton, Md.

## 15

Filed

Jan 21, 1914. Emma S. Youngkin

Deputy REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH

1 21, 1914  
(Month) (Day) (Year)

## 17 I HEREBY CERTIFY, That I attended deceased from

Nov 14, 1913 to Jan 20, 1914

that I last saw him alive on Jan 20, 1914

and that death occurred on the date stated above, at 4-30 A. M.  
The CAUSE OF DEATH\* was as follows:Paralysis & Dropsy  
(Duration) yrs. mos. ds.Contributory  
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

J. T. Younkin

M. D.

Jan 21, 1914 (Address) Brownsville, Md.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

## 19 PLACE OF BURIAL OR REMOVAL

## DATE OF BURIAL

Brownsville

Jan 23, 1914

## 20 UNDERTAKER

## ADDRESS

L. C. Hummer, Jr. Keadysville, Md.

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. B. No. 1.

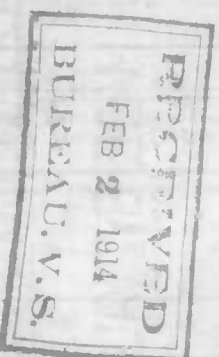
# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not painfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc. *Carcinoma*, *Sarcoma*, etc., of \_\_\_\_\_ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asphyxia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and quality as ACCIDENTAL, suicidal, or homicidal, or as *probably* such. If impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH County <u>Washington</u>		935		STATE OF MARYLAND CERTIFICATE OF DEATH	
Village or City <u>Pleasantville</u> (No. <u>      </u> )		Registered No. <u>310</u>		[If death occurred in a hospital or institution, give its NAME instead of street and number.]	
2 FULL NAME <u>Mary Virginia Rohr</u>		St. <u>      </u> Ward <u>      </u>			
PERSONAL AND STATISTICAL PARTICULARS			MEDICAL CERTIFICATE OF DEATH		
3 SEX <u>Female</u>	4 COLOR OR RACE <u>White</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <u>Single</u>	6 DATE OF DEATH <u>1st 3d</u> , 191 <u>4</u> (Month) (Day) (Year)		
6 DATE OF BIRTH <u>1 3</u> , 191 <u>4</u> (Month) (Day) (Year)			17 I HEREBY CERTIFY, That I attended deceased from <u>Still Born</u> , 191 <u>  </u> to <u>      </u> , 191 <u>  </u> , that I last saw him alive on <u>not at all</u> , 191 <u>  </u> , and that death occurred on the date stated above, at <u>10:30 P.M.</u>		
7 AGE <u>      </u> yrs. <u>      </u> mos. <u>      </u> ds. OR <u>      </u> min. ? If LESS than 1 day, <u>      </u> hrs.			The CAUSE OF DEATH* was as follows: <u>The child perished during the birth</u>		
8 OCCUPATION (a) Trade, profession, or particular kind of work <u>None</u> (b) General nature of industry, business, or establishment in which employed (or employer) <u>      </u>			(Duration) <u>      </u> yrs. <u>      </u> mos. <u>      </u> ds.		
9 BIRTHPLACE (State or country) <u>Md.</u>			Contributory (Secondary) <u>      </u> (Duration) <u>      </u> yrs. <u>      </u> mos. <u>      </u> ds.		
PARENTS	10 NAME OF FATHER <u>Floyd C. Rohr</u>		(Signed) <u>B. B. Ransom</u> , M. D. <u>1st 4th</u> , 191 <u>4</u> , (Address) <u>Harpers Ferry W. Va.</u>		
	11 BIRTHPLACE OF FATHER (State or country) <u>Md.</u>		*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.		
	12 MAIDEN NAME OF MOTHER <u>Minnie M. Moore</u>		18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death <u>      </u> yrs. <u>      </u> mos. <u>      </u> ds. In the State <u>      </u> yrs. <u>      </u> mos. <u>      </u> ds.		
	13 BIRTHPLACE OF MOTHER (State or country) <u>Md.</u>		Where was disease contracted, If not at place of death? Former or usual residence <u>      </u>		
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Floyd C. Rohr</u> (Address) <u>Harpers Ferry, W. Va.</u>					
15 Filed <u>Jan'y 4th</u> , 191 <u>4</u> <u>PM</u> by <u>John McArthur</u> REGISTRAR					
19 PLACE OF BURIAL OR REMOVAL <u>Samplers Manor</u>			DATE OF BURIAL <u>Jan'y 4th</u> , 191 <u>4</u>		
20 UNDERTAKER <u>John McArthur</u>			ADDRESS <u>W. Va.</u>		

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

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**Statement of cause of death**—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc.. *Carcin-*

*oma*, *Sarcoma*, etc., of \_\_\_\_\_ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death). 10 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Anæmia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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## PLACE OF DEATH

936

County WashingtonSTATE OF MARYLAND  
CERTIFICATE OF DEATHRegistered No. 302Village or City Hagerstown (No. 504 Corbit St. — Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

## FULL NAME

Gladys Virginia Rohrer

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX <u>Female</u>	4 COLOR OR RACE <u>White</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <u>Single</u>
6 DATE OF BIRTH <u>Feb.</u> <u>23</u> , 19 <u>10</u> (Month) (Day) (Year)		
7 AGE <u>3</u> yrs. <u>10</u> mos. <u>14</u> ds.		It LESS than 1 day.....hrs. OR.....min. ?

## OCCUPATION

(a) Trade, profession, or particular kind of work None(b) General nature of industry, business, or establishment in which employed (or employer) —BIRTHPLACE  
(State or country)Brown Creek

## PARENTS

## 10 NAME OF FATHER

Harry D. Rohrer11 BIRTHPLACE OF FATHER  
(State or country)Brown Creek

## 12 MAIDEN NAME OF MOTHER

Sarah E. Lutz13 BIRTHPLACE OF MOTHER  
(State or country)Middletown Md

## 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Harry D. Lutz504 Corbit St. Hagerstown Md

## 15

Filed 1/7—1914Harry Davis

REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH

Jan 6, 1914  
(Month) (Day) (Year)

## 17 I HEREBY CERTIFY, That I attended deceased from

Nov 1, 1913 to Jan 6, 1914that I last saw her alive on Jan 5, 1914and that death occurred on the date stated above, at 12 m.

## The CAUSE OF DEATH\* was as follows:

Acute parenchymatous nephritis with acute endocarditisContributory  
(Secondary)1/8 (Duration) yrs. 2 mos. ds.Acute dilatation of heart1/8 (Duration) yrs. 2 mos. ds.

(Signed)

1/6, 1914 (Address) Hagerstown, M. D.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. to the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

## 19 PLACE OF BURIAL OR REMOVAL

Rose Hill Hagerstown Md

## DATE OF BURIAL

Jan. 7, 1914

## 20 UNDERTAKER

Skeller & Townman Hagerstown Md

## ADDRESS

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

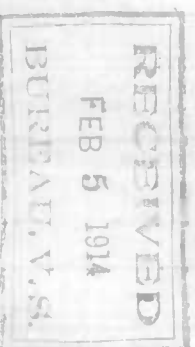
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1 PLACE OF DEATH  
County WASHINGTON

937

Village or City HAGERSTOWN (No. 468 POTOMAC AVE. St.; 4<sup>th</sup> Ward)

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 302

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME UNNAMED CHILD OF WM. & BESSIE ROULETTE.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX MALE 4 COLOR OR RACE WHITE 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED UNNAMED CHILD

6 DATE OF BIRTH JANUARY 20<sup>th</sup>, 1914.  
(Month) (Day) (Year)

7 AGE 15min. If LESS than 1 day, .... hrs. .... min. ?  
yrs. .... mos. .... ds.

8 OCCUPATION  
(a) Trade, profession, or particular kind of work NONE  
(b) General nature of industry, business, or establishment in which employed (or employer) NONE

9 BIRTHPLACE (State or country) MARYLAND.

10 NAME OF FATHER WILLIAM U. ROULETTE.

11 BIRTHPLACE OF FATHER (State or country) MARYLAND.

12 MAIDEN NAME OF MOTHER BESSIE SCHINDEL.

13 BIRTHPLACE OF MOTHER (State or country) MARYLAND.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE  
(Informant) WILLIAM U. ROULETTE

(Address) #468 POTOMAC AVE.

15 Filed 1/20, 1914 Henry Davis  
REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Jan 20, 1914  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Jan 20, 1914, to Jan 20, 1914.

that I last saw him alive on Jan 20, 1914.

and that death occurred on the date stated above, at 2:30 p.m.

The CAUSE OF DEATH\* was as follows:

6 months child, not  
vigil  
died about 15 minutes  
(Duration) .... yrs. .... mos. .... ds.

Contributory  
Secondary

(Duration) .... yrs. .... mos. .... ds.  
(Signed) E. C. Maryhew, M. D.  
Jan 20, 1914. (Address) Hagerstown Md

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death .... yrs. .... mos. .... ds. In the State .... yrs. .... mos. .... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL ROSE HILL CEMETERY DATE OF BURIAL JAN. 20<sup>th</sup>, 1914

20 UNDERTAKER C. M. SUTER & SON ADDRESS HAGERSTOWN MD

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

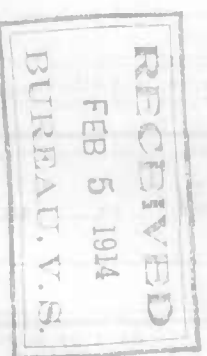
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## 1 PLACE OF DEATH

County

Washington

938

Village or City

Capetown (No. 109, High St.; 5<sup>th</sup> Ward)STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registered No.

302

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

## 2 FULL NAME

Leroy Saunders

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male Colored

4 COLOR OR RACE

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)

Single

6 DATE OF BIRTH

March 2, 1904  
(Month) (Day) (Year)

7 AGE

9 yrs. 10 mos. 16 ds. If LESS than 1 day.....hrs. OR.....min.?

8 OCCUPATION

(a) Trade, profession, or particular kind of work

Child

(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country)

Maryland

10 NAME OF FATHER

James Saunders

11 BIRTHPLACE OF FATHER (State or country)

Maryland

12 MAIDEN NAME OF MOTHER

Emma Lake

13 BIRTHPLACE OF MOTHER (State or country)

Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Emma Saunders

(Address)

Hagerstown Md.

15

Filed

1/19-1914 Henry Davis

REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Jan 18, 1914  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from

at intervals for past 5 years, and

that I last saw him alive on about 10 days ago, 1914

and that death occurred on the date stated above, at 1 p. m.

The CAUSE OF DEATH\* was as follows:

This boy was an idiot, acquired the habit of requesting his food and in my opinion died of starvation self induced (Duration) yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) J. M. Wagman, M. D.

Jan 18, 1914 (Address) Hagerstown Md.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. mos. ds. in the State yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Clearspring

Jan 20, 1914

20 UNDERTAKER

ADDRESS

H. L. L. L.

Hagerstown



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

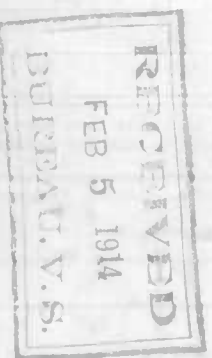
[Approved by U. S. Census and American Public Health Association.]

**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Ore mining*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

*oma*, *Sarcoma*, etc., of \_\_\_\_\_ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 *ds.*; *Bronchopneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "Anaemia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Ivanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PLACE OF DEATH

939

County

Village or City

(No.

St;

Ward)

Registered No.

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

FULL NAME

PERSONAL AND STATISTICAL PARTICULARS

SEX

COLOR OR RACE

SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)

DATE OF BIRTH

AGE

If LESS than 1 day.....hrs. yrs.....mos.....ds. OR.....min.?

OCCUPATION

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

BIRTHPLACE (State or country)

NAME OF FATHER

BIRTHPLACE OF FATHER (State or country)

MAIDEN NAME OF MOTHER

BIRTHPLACE OF MOTHER (State or country)

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Filed

15

REGISTRAR

STATE OF MARYLAND  
CERTIFICATE OF DEATH

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH

(Month) (Day) (Year)

I HEREBY CERTIFY, That I attended deceased from

that I last saw him alive on

and that death occurred on the date stated above, at

The CAUSE OF DEATH\* was as follows:

Contributory (Secondary)

(Duration) yrs.....mos.....ds.

(Duration) yrs.....mos.....ds.

(Signed) M. D.

(Address)

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs.....mos.....ds. In the State yrs.....mos.....ds.

Where was disease contracted, If not at place of death?

Former or usual residence

PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

UNDERTAKER

ADDRESS

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

Approved by U. S. Census and American Public Health Association.]

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RECEIVED

FEB 5 1914

BUREAU, V.S.



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

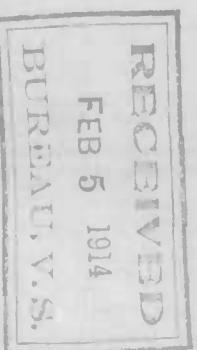
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WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH County <u>Washington</u> 941		STATE OF MARYLAND CERTIFICATE OF DEATH	
Village or City <u>Charlton</u> (No. <u>157</u> )		Registration Dist. No. <u>303</u>	
2 FULL NAME <u>John Benjamin Shank</u>			
PERSONAL AND STATISTICAL PARTICULARS			
3 SEX <u>Male</u>	4 COLOR OR RACE <u>White</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED <u>Widowed</u> (Write the word)	
6 DATE OF BIRTH <u>July 26, 1849</u> (Month) (Day) (Year)			
7 AGE <u>64</u> yrs. <u>11</u> mos. <u>9</u> ds. It LESS than 1 day, hrs. OR min. ?			
8 OCCUPATION (a) Trade, profession, or particular kind of work <u>Farmer</u> (b) General nature of industry, business, or establishment in which employed (or employer) <u>retired</u>			
9 BIRTHPLACE (State or country) <u>Washington Co. Md.</u>			
PARENTS	10 NAME OF FATHER <u>Henry Shank</u>		
	11 BIRTHPLACE OF FATHER (State or country) <u>Md.</u>		
	12 MAIDEN NAME OF MOTHER <u>Lydia Rowland</u>		
13 BIRTHPLACE OF MOTHER (State or country) <u>Md.</u>			
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Henry Shank</u> (Address) <u>Big Spring Md.</u>			
15 Filed <u>Jan 5, 1914</u> <u>David S. Miller</u> REGISTRAR			
MEDICAL CERTIFICATE OF DEATH			
16 DATE OF DEATH <u>January 5, 1914</u> (Month) (Day) (Year)			
17 I HEREBY CERTIFY, That I attended deceased from <u>191</u> to <u>191</u> , that I last saw him alive on <u>191</u> , and that death occurred on the date stated above, at <u>m</u> . The CAUSE OF DEATH* was as follows: <u>Strangled by rope</u> <u>Self inflicted—suicidal</u> (Duration) <u>1</u> yrs. <u>11</u> mos. <u>9</u> ds. Contributory <u>Failing health</u> Secondary (Duration) <u>1</u> yrs. <u>11</u> mos. <u>9</u> ds. (Signed) <u>David S. Miller, M. D.</u> <u>Jan 5, 1914</u> (Address) <u>Clear Spring Md.</u>			
*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.			
18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death <u>1</u> yrs. <u>11</u> mos. <u>9</u> ds. In the State <u>1</u> yrs. <u>11</u> mos. <u>9</u> ds. Where was disease contracted, If not at place of death? Former or usual residence <u>Clear Spring Md.</u>			
19 PLACE OF BURIAL OR REMOVAL <u>Memorial grove</u>		DATE OF BURIAL <u>Jan 8, 1914</u>	
20 UNDERTAKER <u>Frederic B. B. Co.</u>		ADDRESS <u>Clear Spring</u>	

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

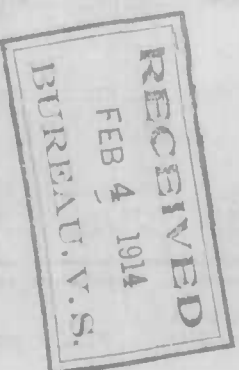
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## 1 PLACE OF DEATH

County

Washington

942

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registered No. 307

Village or City

Rohrersville Md

(No.)

St;

Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

## 2 FULL NAME

Eliza A Slifur

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female* 4 COLOR OR RACE *White* 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED *Married*  
(Write the word)

## 6 DATE OF BIRTH

*10* *21*, 19*47*  
(Month) (Day) (Year)

## 7 AGE

*66* yrs. *2* mos. *19* ds. if LESS than 1 day, hrs. OR min. ?

## 8 OCCUPATION

(a) Trade, profession, or particular kind of work

*None*

(b) General nature of industry, business, or establishment in which employed (or employer)

*None*

## 9 BIRTHPLACE (State or country)

*Rohrersville Ma*

## PARENTS

## 10 NAME OF FATHER

*Wm Haynes*

## 11 BIRTHPLACE OF FATHER (State or country)

*Rohrersville Ma*

## 12 MAIDEN NAME OF MOTHER

*Mary Buck*

## 13 BIRTHPLACE OF MOTHER (State or country)

*Kearcyville Ma*

## 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

*Joshua Slifur*

(Address)

*Rohrersville Ma*

## 15

Filed *Jan 2*, 19*48* *C. S. Baker* M.D.  
*Local* REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH

*1* *21*, 19*48*  
(Month) (Day) (Year)

## 17

I HEREBY CERTIFY, That I attended deceased from

....., 191....., to ..... , 191.....

that I last saw him alive on *Dec 28*, 191*3*and that death occurred on the date stated above, at *12:30 A.M.*

The CAUSE OF DEATH\* was as follows:

*Angina Pectoris*  
*from history of same*

(Duration) ..... yrs. .... mos. .... ds. *1 hour*

Contributory (Secondary)

(Duration) ..... yrs. .... mos. .... ds.

(Signed)

*E. S. Baker*

, M. D.

*1* *30*, 191*4* (Address) *Rohrersville*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ..... yrs. .... mos. .... ds. to the State ..... yrs. .... mos. .... ds.

Where was disease contracted,

if not at place of death?

Former or

usual residence.

## 19 PLACE OF BURIAL OR REMOVAL

## DATE OF BURIAL

*Rohrersville Ma* *1-4*, 191*4*

## 20 UNDERTAKER

## ADDRESS

*C. L. Duman & Co* *Kearcyville*

*Ma*

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

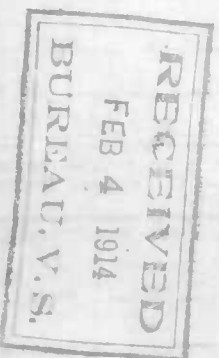
[Approved by U. S. Census and American Public Health Association.]

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**Statement of cause of death**—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc. *Carcin-*

*oma*, *Sarcoma*, etc., of \_\_\_\_\_ (name organ; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 *ds.*; *Bronchopneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Traemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septicaemia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, suicidal, or HOMICIDAL, or as *probably* such. If impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of heart—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH			943		STATE OF MARYLAND CERTIFICATE OF DEATH		170		309		
County <u>Washington</u>					Registered No. <u>309</u>				[It death occurred in a hospital or institution, give its NAME instead of street and number.]		
Village or City <u>Clearspring</u>			(No. ....)		St. ....		Ward) ....				
2 FULL NAME <u>Ann E. Smith</u>											
PERSONAL AND STATISTICAL PARTICULARS						MEDICAL CERTIFICATE OF DEATH					
3 SEX <u>Female</u>		4 COLOR OR RACE <u>white</u>		5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <u>widowed</u>		16 DATE OF DEATH <u>1</u> <u>9</u> , 191 <u>4</u> (Month) (Day) (Year)					
6 DATE OF BIRTH <u>July</u> <u>26</u> - <u>1828</u> (Month) (Day) (Year)						17 I HEREBY CERTIFY, That I attended deceased from <u>May 19</u> , 191 <u>3</u> , to <u>Jan 8</u> , 191 <u>4</u> , that I last saw h <u>er</u> alive on <u>Dec. 24</u> , 191 <u>3</u>					
7 AGE <u>85</u> yrs. <u>5</u> mos. <u>14</u> ds.				It LESS than 1 day. .... hrs. OR .... min. ?		and that death occurred on the date stated above, at <u>1-55 A.</u> m.					
8 OCCUPATION (a) Trade, profession, or particular kind of work <u>House woman</u> (b) General nature of industry, business, or establishment in which employed (or employer) .....						The CAUSE OF DEATH* was as follows: <u>Chronic Nephritis</u>					
9 BIRTHPLACE (State or country) <u>Penn</u>						Contributory (Secondary) .....					
10 NAME OF FATHER <u>Abraham Roland</u>						(Duration) <u>2</u> yrs. .... mos. .... ds.					
11 BIRTHPLACE OF FATHER (State or country) <u>Penn</u>						(Signed) <u>H. C. Hostet</u> , M. D. <u>Jan 9</u> , 191 <u>4</u> (Address) <u>Clearspring</u>					
12 MAIDEN NAME OF MOTHER <u>Anna Funk</u>						*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.					
13 BIRTHPLACE OF MOTHER (State or country) <u>Penn</u>						18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death .... yrs. .... mos. .... ds. In the State .... yrs. .... mos. .... ds. Where was disease contracted, If not at place of death? Former or usual residence .....					
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Charles L. Smith</u> (Address) <u>Clearspring</u>						19 PLACE OF BURIAL OR REMOVAL <u>Clearspring</u> DATE OF BURIAL <u>Jan 11</u> , 191 <u>4</u> <u>Methodist</u>					
15 Filed <u>Jan 9</u> , 191 <u>4</u> <u>Darius S. Mee</u> REGISTRAR						20 UNDERTAKER <u>L. P. Snyder</u> ADDRESS <u>Clearspring Md</u>					



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

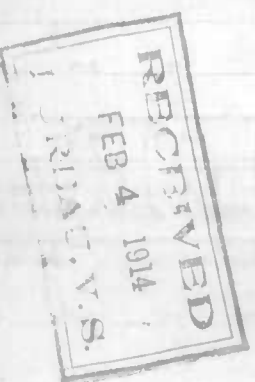
[Approved by U. S. Census and American Public Health Association.]

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**Statement of cause of death**—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc. *Carcin-*

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## 1 PLACE OF DEATH

944

STATE OF MARYLAND  
CERTIFICATE OF DEATHCounty WashingtonRegistered No. 201Village or City Rogersville(No. 13 Mar 14)St. 3 Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

## 2 FULL NAME

Quincy A. Sprecher

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Widower

## 6 DATE OF BIRTH

Jan 4, 1899  
(Month) (Day) (Year)

## 7 AGE

76 yrs. — mos. 10 ds. 11 LESS than 1 day, .... hrs. OR .... min. ?

## 8 OCCUPATION

(a) Trade, profession, or particular kind of work

Gardner

(b) General nature of industry, business, or establishment in which employed (or employer)

C

## 9 BIRTHPLACE (State or country)

Maryland

## 10 NAME OF FATHER

David Sprecher

## 11 BIRTHPLACE OF FATHER (State or country)

Maryland

## 12 MAIDEN NAME OF MOTHER

Mary Bear

## 13 BIRTHPLACE OF MOTHER (State or country)

Maryland

## 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) David Sprecher(Address) Rogersville Md

## 15

Filed 1/15, 1914 Henry Davis  
REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH

January 15, 1914  
(Month) (Day) (Year)

## 17 I HEREBY CERTIFY, That I attended deceased from

January 14, 1914, to January 15, 1914,  
that I last saw him alive on January 14, 1914

and that death occurred on the date stated above, at 5 a.m.

The CAUSE OF DEATH\* was as follows:

Paralysis

## Contributory (Secondary)

Defective Heart and  
Home Temperature (Duration) .... yrs. .... mos. .... ds.

(Signed) Chas. D. Boyle, M. D.

January 15, 1914. (Address) Rogersville

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death .... yrs. .... mos. .... ds. 10 State .... yrs. .... mos. .... ds.

Where was disease contracted,  
If not at place of death?

Former or usual residence

## 19 PLACE OF BURIAL OR REMOVAL

## DATE OF BURIAL

Rogersville Md Jan 17, 1914

## 20 UNDERTAKER

## ADDRESS

St. Ignace Rogersville

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

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**Statement of cause of death**—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc.. *Carcin-*

*oma*, *Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic tubular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Delirium" ("Congential," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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RECEIVED  
FEB 5 1914  
BUREAU, V. S.

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## 1 PLACE OF DEATH

945

County WashingtonVillage or City Williamsport (No. Potomac) St.; \_\_\_\_\_ Ward)STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistered No. 301

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Ola May Stiff

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDDED, OR DIVORCED Married  
(Write the word)

6 DATE OF BIRTH Aug 5th, 1891  
(Month) (Day) (Year)

7 AGE 22 yrs. 5 mos. 13 ds. If LESS than 1 day.....hrs. OR.....min.?

8 OCCUPATION  
(a) Trade, profession, or particular kind of work House wife  
(b) General nature of industry, business, or establishment in which employed (or employer) House wife

9 BIRTHPLACE (State or country) Virginia

10 NAME OF FATHER Jacklin Jackson

11 BIRTHPLACE OF FATHER (State or country) Virginia

12 MAIDEN NAME OF MOTHER Lucy B. Boxwell

13 BIRTHPLACE OF MOTHER (State or country) Virginia

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) T. A. Russell  
(Address) Williamsport, Md.

15 Filed Jan. 19, 1914 C. E. Rickard  
Local REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Jan. 18, 1914  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Dec 4, 1913 to Jan 18, 1914

that I last saw her alive on Jan. 18, 1914

and that death occurred on the date stated above, at 5 A. m.

The CAUSE OF DEATH\* was as follows:

Pulmonary tuberculosis

Contributory (Secondary) Heart failure  
(Duration) 2 yrs. 4 mos. 4 ds.

(Signed) Walter Layman, M. D.  
Jan. 19, 1914 (Address) Williamsport

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. In the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence.

19 PLACE OF BURIAL OR REMOVAL Manchester, Pa. DATE OF BURIAL Jan 21, 1914

20 UNDERTAKER Lewis W. Kripe ADDRESS Williamsport, Md.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

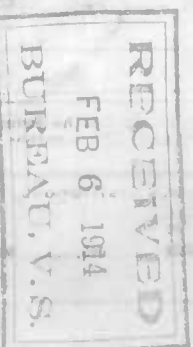
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## 1 PLACE OF DEATH

County Washington

946

STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistered No. 202Village or City Rogersstown (No. 39 East Ave)St. 4th Ward

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Jacob S. Stauffer

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White5 SINGLE,  
MARRIED,  
WIDOWED,  
OR DIVORCED  
(Write the word)Widower

6 DATE OF BIRTH

Jan 13, 1842  
(Month) (Day) (Year)

7 AGE

71 yrs. 11 mos. 25 ds. If LESS than  
1 day.....hrs.  
OR.....min.?

8 OCCUPATION

(a) Trade, profession, or particular kind of work

Farmer Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE  
(State or country)Maryland

## PARENTS

10 NAME OF FATHER

Christian Stauffer11 BIRTHPLACE OF FATHER  
(State or country)Maryland

12 MAIDEN NAME OF MOTHER

Roxanna Thomas13 BIRTHPLACE OF MOTHER  
(State or country)Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Effie M. Stauffer

(Address)

Rogersstown

15

Filed

1/14, 1914 H. H. Davis

REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Jun 13, 1914  
(Month) (Day) (Year)

17

I HEREBY CERTIFY, That I attended deceased from

\_\_\_\_\_, 191\_\_\_\_, to \_\_\_\_\_, 191\_\_\_\_,

that I last saw him \_\_\_\_\_ alive on Jun 12, 1914and that death occurred on the date stated above, at 3:30 A.M.

The CAUSE OF DEATH\* was as follows:

Sudden • Embolism  
indicates Oedema of Lungs  
(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.Contributory  
(Secondary)

(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

(Signed)

J. S. Stauffer, M. D.  
Jan 15, 1914 (Address) Rogersstown

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

16 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. In the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Where was disease contracted, if not at place of death?

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Rogersstown Md Jan 15, 1914

20 UNDERTAKER

ADDRESS

H. H. Davis Rogersstown

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

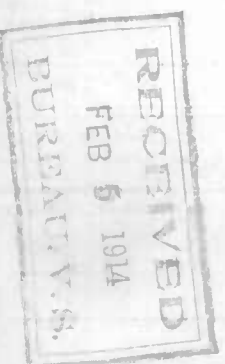
# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc. *Carcinoma*, *Sarcoma*, etc., of ..... (name organ; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic tubular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Anaemia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential," "Senile," etc.), "Dropsey," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and quality as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH County <u>Washington</u> 947		STATE OF MARYLAND CERTIFICATE OF DEATH	
Village or City <u>Boonsboro</u> (No. <u>124</u> )		Registration Dist. No. <u>305</u>	
2 FULL NAME <u>Benjamin Franklin Thomas</u>		[If death occurred in a hospital or institution, give its NAME instead of street and number.]	
PERSONAL AND STATISTICAL PARTICULARS			
3 SEX <u>Male</u>	4 COLOR OR RACE <u>white</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED <u>Married</u> (Write the word)	
6 DATE OF BIRTH <u>Feb 23</u> , 18 <u>86</u> (Month) (Day) (Year)			
7 AGE <u>77</u> yrs. <u>11</u> mos. <u>7</u> ds. <u>OR</u> LESS than 1 day, <u>hrs.</u> <u>min.</u> ?			
8 OCCUPATION (a) Trade, profession, or particular kind of work <u>Labour</u> (b) General nature of industry, business, or establishment in which employed (or employer)			
9 BIRTHPLACE (State or country) <u>Maryland</u>			
PARENTS	10 NAME OF FATHER <u>Peter Thomas</u>		
	11 BIRTHPLACE OF FATHER (State or country) <u>Maryland</u>		
	12 MAIDEN NAME OF MOTHER <u>Polly Smith</u>		
	13 BIRTHPLACE OF MOTHER (State or country) <u>Maryland</u>		
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Chris Benjamin Thomas</u> (Address) <u>Boonsboro, Md.</u>			
15 FILED <u>Jan 31</u> , 191 <u>4</u> <u>Geo. M. Storr</u> REGISTRAR			
MEDICAL CERTIFICATE OF DEATH			
16 DATE OF DEATH <u>Jan 30</u> , 191 <u>4</u> (Month) (Day) (Year)			
17 I HEREBY CERTIFY, That I attended deceased from <u>Oct 14</u> , 191 <u>3</u> , to <u>Jan 30</u> , 191 <u>4</u> , that I last saw him alive on <u>Jan 27</u> , 191 <u>4</u> , and that death occurred on the date stated above, at <u>9:30 a.</u> m. The CAUSE OF DEATH* was as follows: <u>Uremia</u> (Duration) <u>0</u> yrs. <u>0</u> mos. <u>7</u> ds. Contributory <u>Chronic Cystitis</u> Secondary (Duration) <u>1</u> yrs. <u>3</u> mos. <u>0</u> ds. (Signed) <u>W. C. Webster</u> , M. D. <u>Jan 31</u> , 191 <u>4</u> (Address) <u>Boonsboro, Md.</u>			
*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.			
18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death <u>      </u> yrs. <u>      </u> mos. <u>      </u> ds. In the State <u>      </u> yrs. <u>      </u> mos. <u>      </u> ds. Where was disease contracted, If not at place of death? Former or usual residence <u>      </u>			
19 PLACE OF BURIAL OR REMOVAL <u>Boonsboro Cemetery</u>		DATE OF BURIAL <u>Feb 2</u> , 191 <u>4</u>	
20 UNDERTAKER <u>William F. Best Boonsboro</u>		ADDRESS <u>      </u>	

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

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*oma, Sarcoma, etc., of.....* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic interstitial nephritis; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds.* Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Con-renal," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal, septicaemia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolie acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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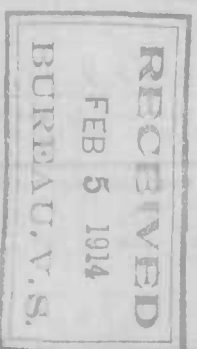
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1 PLACE OF DEATH 949  
 County Washington  
 Village or City Clear Spring Dist. No. 90 St. \_\_\_\_\_ Ward \_\_\_\_\_  
 2 FULL NAME Elsie Virginia Williams  
 [If death occurred in a hospital or institution, give its NAME instead of street and number.]

Registration Dist. No. 314

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE Negro 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)  
 6 DATE OF BIRTH Sept. 7, 1913  
 (Month) (Day) (Year)  
 7 AGE 0 yrs. 3 mos. 27 ds. OR 1 day, \_\_\_\_\_ hrs. 27 min. ?

8 OCCUPATION  
 (a) Trade, profession, or particular kind of work  
 (b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) Big Spring Md.

PARENTS  
 10 NAME OF FATHER E. A. Williams  
 11 BIRTHPLACE OF FATHER (State or country) Wash. Ind.  
 12 MAIDEN NAME OF MOTHER B. A. Hall  
 13 BIRTHPLACE OF MOTHER (State or country) Hancock Ind.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) E. A. Williams  
 (Address) Big Spring Ind.

15 Filed Jan. 2, 1914 W. S. Hall  
 REGISTRAR

STATE OF MARYLAND  
CERTIFICATE OF DEATH

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH January 2nd, 1914  
 (Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Dec. 27th, 1913 to Jan. 1st, 1914.

that I last saw her alive on Jan. 1st, 1914.

and that death occurred on the date stated above, at 2 P. m.

The CAUSE OF DEATH\* was as follows:

Capillary Bronchitis.

(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. 4 ds.

Contributory  
 Secondary

(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

(Signed) Jonathan P. Perry, M. D.  
Jan. 2nd, 1914 (Address) Clear Spring Ind.

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18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. In the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Where was disease contracted, If not at place of death?

Former or usual residence.

19 PLACE OF BURIAL OR REMOVAL Chapel grave yard DATE OF BURIAL Jan 4, 1914

20 UNDERTAKER Frank Perry & Co ADDRESS Clear Spring

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

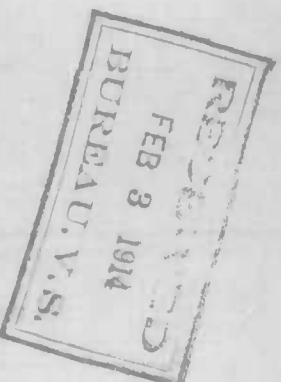
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950

## 1 PLACE OF DEATH

County

Washington

Village or City

Funketown

(No. 144)

St. Ward

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 309

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

## 2 FULL NAME

John Frederick Williams

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)

Single

6 DATE OF BIRTH

Nov

13

1913

(Month)

(Day)

(Year)

7 AGE

2

11

If LESS than

1 day, hrs.

OR min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE

(State or country)

Md

PARENTS

10 NAME OF FATHER

John R. Frederick

11 BIRTHPLACE OF FATHER (State or country)

Md

12 MAIDEN NAME OF MOTHER

Blanch R. Shilling

13 BIRTHPLACE OF MOTHER (State or country)

Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

John R. Frederick

(Address)

Funketown Md

15

Filed

Jan. 26, 1914

M. S. Miller

REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

January 25

(Month)

(Day)

(Year)

17

I HEREBY CERTIFY, that I attended deceased from

Nov 13

1914

to January 25

1914

that I last saw him alive on

January 23

1914

and that death occurred on the date stated above, at 7 a. m.

The CAUSE OF DEATH\* was as follows:

abscess of glands of the neck

Cause of death (Duration) yrs. mos. ds.

Contributory Secondary Inflamm. of glands

(Duration) yrs. mos. ds.

(Signed) Chas. B. Boyle, M. D.

Jany 25, 1914. (Address) Funketown

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At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

Funketown

DATE OF BURIAL

126

1914

20 UNDERTAKER

J. H. Telt

ADDRESS

Funketown Md

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

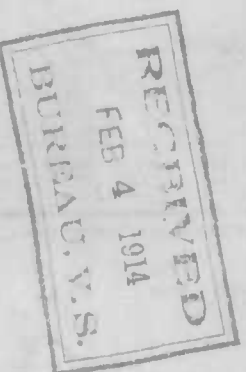
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**Statement of cause of death**—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meningis, peritonacum*, etc., *Carcin-*

*oma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal *septicæmia*," "Puerperal *peritonitis*," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Reverber wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH 951  
County Washington

Village or City Hancock Md. (No. 178)

2 FULL NAME Lola Williams

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 304

St. \_\_\_\_\_ Ward \_\_\_\_\_

[It death occurred in a hospital or institution, give its NAME instead of street and number.]

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE Colored 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Single  
(Write the word)

8 DATE OF BIRTH Feb 7, 1896  
(Month) (Day) (Year)

7 AGE 17 yrs. 11 mos. 7 ds. It LESS than 1 day, \_\_\_ hrs. OR \_\_\_ min. ?

8 OCCUPATION  
(a) Trade, profession, or particular kind of work Servant.  
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) Hancock Md.

10 NAME OF FATHER Henry Williams

11 BIRTHPLACE OF FATHER (State or country) Caroline Co. Va.

12 MAIDEN NAME OF MOTHER Louisa Reed.

13 BIRTHPLACE OF MOTHER (State or country) Hancock Md.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE  
(Informant) Henry Williams

(Address) Hancock Md.

15 Jan. 15th, 1914 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Jan. 14th, 1914  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Dec 20th, 1913, to Jan 14th, 1914, that I last saw her alive on Jan 14th, 1914

and that death occurred on the date stated above, at 4 P. m.

The CAUSE OF DEATH\* was as follows:

Pulmonary Tuberculosis  
have been in attendance only  
from above date do not know duration  
(Duration) \_\_\_ yrs. \_\_\_ mos. \_\_\_ ds.

Contributory (Secondary) \_\_\_\_\_  
(Duration) \_\_\_ yrs. \_\_\_ mos. \_\_\_ ds.

(Signed) J. J. J. J. J. M. D.  
1/14/14, 1914 (Address) Hancock Md.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death \_\_\_ yrs. \_\_\_ mos. \_\_\_ ds. In the State \_\_\_ yrs. \_\_\_ mos. \_\_\_ ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Hancock Maryland DATE OF BURIAL Jan 16th, 1914

20 UNDERTAKER M. Jenkins & Son ADDRESS Hancock Md.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

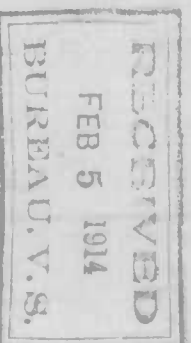
[Approved by U. S. Census and American Public Health Association.]

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**Statement of cause of death**—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc.. *Carcin-*

*oma*, *Sarcoma*, etc., of ----- (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asphyxia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Tremor," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septicemia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and quality as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such. If impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH

952

County

Washington

Village or City Hagerstown (No. 138 E. Washington St.; 3<sup>rd</sup> Ward)STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registered No.

302

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

Edward Wilson.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

male

4 COLOR OR RACE

white

5 SINGLE,  
MARRIED,  
WIDOWED,  
ORDIVORCED  
(Write the word)

married

6 DATE OF BIRTH

July 4<sup>th</sup>, 1877.  
(Month) (Day) (Year)

7 AGE

36 yrs. 6 mos. — ds. If LESS than  
1 day, — hrs. OR — min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work

R. R. Laborer.

(b) General nature of industry, business, or establishment in which employed (or employer)

Railroad.

9 BIRTHPLACE  
(State or country)

Maryland.

10 NAME OF FATHER

Granville Wilson

11 BIRTHPLACE OF FATHER  
(State or country)

Maryland.

12 MAIDEN NAME OF MOTHER

Anna Bowers.

13 BIRTHPLACE OF MOTHER  
(State or country)

Maryland.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Emile Wilson.

(Address)

138 E. Washington St.

15

Filed

1/6-1914 Henry Davis

REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Jan 4, 1914  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from

Jan 1910, to Jan 4, 1914.

that I last saw him alive on Jan 4, 1914.

and that death occurred on the date stated above, at 6:30 a. m.

The CAUSE OF DEATH\* was as follows:

Chronic Interstitial  
nephritis

(Duration) 3 yrs. — mos. — ds.

Contributory  
(Secondary)

(Duration) — yrs. — mos. — ds.

(Signed) Daniel A. Watkins, M. D.

Jan 4, 1914 (Address) Hagerstown Md.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death — yrs. — mos. — ds. In the State — yrs. — mos. — ds.

Where was disease contracted,

If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Rev. Bill Crutten 1/6, 1914.

20 UNDERTAKER

ADDRESS

Edw. L. Lox Hagerstown, Md.

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

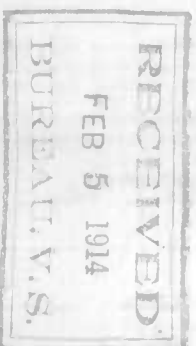
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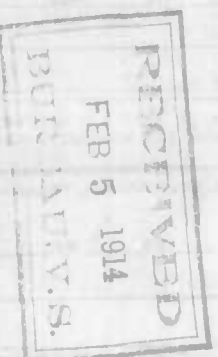
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1 PLACE OF DEATH 954  
County Washington

Village or City Kearneysville (No. Ma 64)

2 FULL NAME Lydia Hyman

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registered No. 312

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Widowed  
(Write the word)

6 DATE OF BIRTH 2 10 1833  
(Month) (Day) (Year)

7 AGE 80 yrs. 11 mos. 5 ds. If LESS than 1 day.....hrs. OR.....min. ?

8 OCCUPATION  
(a) Trade, profession, or particular kind of work None  
(b) General nature of industry, business, or establishment in which employed (or employer) None

9 BIRTHPLACE (State or country) Beaver Dam Ford Co

10 NAME OF FATHER John E. Clark

11 BIRTHPLACE OF FATHER (State or country) Beaver Dam Ford Co

12 MAIDEN NAME OF MOTHER Mary M. Buser

13 BIRTHPLACE OF MOTHER (State or country) Beaver Dam Ford Co

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Fred M. Pateman

(Address) Kearneysville Md

15 Filed Jan 16, 1914 H. H. Sumner

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Jan 15, 1914  
(Month) (Day) (Year)

17 I HEREBY CERTIFY That I attended deceased from Dec 28, 1913, to Jan 15, 1914.

that I last saw him alive on Jan 15, 1914.

and that death occurred on the date stated above, at 3 a. m.

The CAUSE OF DEATH\* was as follows:

cerebral thrombosis

(Duration) ..... yrs. .... mos. .... ds.

Contributory (Secondary)

(Duration) ..... yrs. .... mos. .... ds.

(Signed) H. H. Sumner, M. D.

Jan 16, 1914. (Address) Kearneysville Md

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ..... yrs. .... mos. .... ds. in the State ..... yrs. .... mos. .... ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Kearneysville Md DATE OF BURIAL 1-17, 1914

20 UNDERTAKER C. L. Sumner & Co ADDRESS Kearneysville Md

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

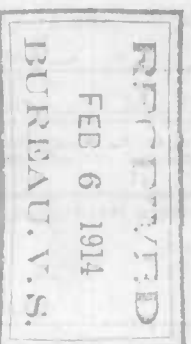
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**Statement of cause of death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc. *Carcin-*

*oma*, *Sarcoma*, etc., of \_\_\_\_\_ (name or origin: "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Paralysis," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septicemia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such. If impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## PLACE OF DEATH

County Washington

955

STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistered No. 302Village or City Hagerstown(No. 121 Elm

St; Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

FULL NAME Albertus Zeager

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) married

6 DATE OF BIRTH March 10, 1857  
(Month) (Day) (Year)

7 AGE 57 yrs. 9 mos. 29 ds. If LESS than 1 day, .... hrs. OR .... min. ?

8 OCCUPATION  
(a) Trade, profession, or particular kind of work Gaboner  
(b) General nature of industry, business, or establishment in which employed (or employer) C

9 BIRTHPLACE (State or country) Pennsylvania

10 NAME OF FATHER David Zeager

11 BIRTHPLACE OF FATHER (State or country) Pennsylvania

12 MAIDEN NAME OF MOTHER Elizabeth Collier

13 BIRTHPLACE OF MOTHER (State or country) Pennsylvania

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs Albertus Zeager

(Address) Hagerstown, Md

15 Filed 1/10, 1914 Henry Davis REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH January 9, 1914  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from January 9, 1914 to January 9, 1914, that I last saw him alive on January 9, 1914 and that death occurred on the date stated above, at 7:30 P.m. The CAUSE OF DEATH\* was as follows:

Val. disease of the heart

Six years (Duration) yrs. mos. ds.

Contributory (Secondary)

Heart

(Signed) Chas. D. Boyle, M. D.

, 191 (Address) Hagerstown, Md

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Hagerstown, Md Jan 11, 1914

20 UNDERTAKER

ADDRESS

H. C. Hoffman Hagerstown

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

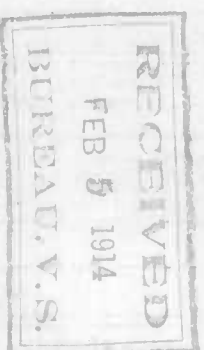
[Approved by U. S. Census and American Public Health Association.]

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Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc.. *Carcin-*

*oma*, *Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Con- genital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Maras- mus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septiche- mia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VO- LUNT DEATHS state MEANS OF INJURY and quality as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—ac- cident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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956

## 1 PLACE OF DEATH

County WashingtonVillage or City Boonsboro

(No. \_\_\_\_\_)

St.; \_\_\_\_\_ Ward)

STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 305-

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Silas Young

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Married  
(Write the word)

## 6 DATE OF BIRTH

Sept 22, 1846  
(Month) (Day) (Year)

## 7 AGE

67 yrs. 5 mos. 27 ds. OR 1 day, hrs. min. ?  
It LESS than 1 day, hrs. min. ?

## 8 OCCUPATION

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

Retired Farmer

## 9 BIRTHPLACE

(State or country)

Maryland

## PARENTS

## 10 NAME OF FATHER

Greenbury Young

## 11 BIRTHPLACE OF FATHER

(State or country)

Maryland

## 12 MAIDEN NAME OF MOTHER

Sarah Hulgel

## 13 BIRTHPLACE OF MOTHER

(State or country)

Maryland

## 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Jennie Young

(Address)

Boonsboro Md

## 15

Filed Jan 22, 1914 Geo. M. Stone, Jr.

REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH

Jan 19<sup>th</sup>, 1914  
(Month) (Day) (Year)

## 17

I HEREBY CERTIFY, That I attended deceased from

Feb, 1910, to Jan 19<sup>th</sup>, 1914.

that I last saw him alive on Jan 19<sup>th</sup>, 1914.

and that death occurred on the date stated above, at 5 P. m.

The CAUSE OF DEATH\* was as follows:

Phthisis Pulmonalis(Duration) 4 yrs. — mos. — ds.Contributory  
Secondary

(Duration) — yrs. — mos. — ds.

(Signed)

W. C. Tebbel, M. D.

Jan 21, 1914. (Address) Boonsboro Md

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

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At place of death — yrs. — mos. — ds. In the State — yrs. — mos. — ds.

Where was disease contracted,  
If not at place of death?

Former or  
usual residence.

## 19 PLACE OF BURIAL OR REMOVAL

## DATE OF BURIAL

Boonsboro Cemetery Jan 22, 1914

## 20 UNDERTAKER

## ADDRESS

William F. Best Boonsboro Md

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

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